Filing at a Glance

Company:	Colonial Life & Accident Insurance Company
Product Name:	Group Critical Illness/Cancer
State:	District of Columbia
TOI:	H07G Group Health - Specified Disease - Limited Benefit
Sub-TOI:	H07G.001 Critical Illness
Filing Type:	Form
Date Submitted:	01/13/2020
SERFF Tr Num:	UNUM-132106302
SERFF Status:	Closed-APPROVED
State Tr Num:	
State Status:	
Co Tr Num:	GCI6000 - FORMS
Implementation Date Requested:	On Approval
Author(s):	Cathy Brooks, Tyra Marshall, Brandi Wessinger, Stephany Suite
Reviewer(s):	Colin Johnson (primary), RaShaunda Benson
Disposition Date:	02/06/2020
Disposition Status:	APPROVED
Implementation Date:	02/06/2020

State: *District of Columbia* **Filing Company:** *Colonial Life & Accident Insurance Company*
TOI/Sub-TOI: *H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*
Product Name: *Group Critical Illness/Cancer*
Project Name/Number: *Group Critical Illness/Cancer /GCI6000*

General Information

Project Name: Group Critical Illness/Cancer
Project Number: GCI6000
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer, Association, Other
Overall Rate Impact:

Deemer Date:
Submitted By: Brandi Wessinger

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: SC is the domicile state
Market Type: Group
Group Market Size: Small and Large
Explanation for Other Group Market Type: Unions
Filing Status Changed: 02/06/2020
State Status Changed:
Created By: Brandi Wessinger
Corresponding Filing Tracking Number: UNUM-132106301

Filing Description:
RE:NAIC#:0565 / 62049
Insurer:Colonial Life & Accident Insurance Company
Forms: GCI6000-P, et al
Type of Filing: Group Specified Disease

Dear Commissioner:
Attached for your review and approval are our new group specified disease policy, certificate, riders, and associated forms.

Form	Description	Flesch Score
GCI6000-P	Group Specified Disease Master Policy	52.1
GCI6000-C-DC	Group Specified Disease Certificate	51.8
R-GCI6000-CB	Group Cancer Benefits Rider	50.6
R-GCI6000-BB	Group First Diagnosis Building Benefit Rider	50.3
R-GCI6000-HB-DC	Group Heart Benefits Rider	50.6
R-GCI6000-INF-DC	Group Infectious Diseases Rider	50.4
R-GCI6000-PD-DC	Group Progressive Diseases Rider	50.7
GCI6000 Port-DC	Election of Group Specified Disease Insurance Portability Coverage	
GCI6000 Enroll-DC	Group Specified Disease Insurance Enrollment Form	
GCI6000 E of I-DC	Group Specified Disease Insurance Evidence of Insurability Form	
GCI6000SD19	Group Specified Disease Supplemental Data Form	

The forms do not replace any forms currently on file with your department. The readability scores for these forms are listed above. The text of the forms is uniform and no less than ten (10) point font size.

These forms will be offered and marketed primarily at the worksite as supplemental insurance and not as a substitute for hospital or medical expense insurance or major medical insurance. Benefits provided are not intended to cover all medical expenses. There is no coordination of benefits. Please note all benefits are indemnity based.

These forms do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Coverage will be marketed to employer/employee groups by licensed Colonial Life & Accident Insurance Company agents and through relationships with insurance brokers. Premiums may be paid 100% by the employees or by full or partial contributions

from the policyholder. This coverage may be marketed to associations and unions.

The group specified disease policy and certificate provides benefits for several critical illness conditions, additional critical illnesses for dependent children and cancer. The group policy also provides an optional Wellbeing Assistance Benefit.

We are also submitting several optional riders that provide coverage for supplemental critical illnesses, cancer, heart procedures, infectious diseases and progressive diseases.

Coverage amounts and which optional riders to offer will be chosen by the policyholder. The named insured will be able to select coverage options to meet their needs. The issue ages for this product will range from 16-74. Benefits are also available for spouse and dependent children.

Bracketed information is variable and may be removed or altered. A Statement of Variability is included with this filing and provides more detailed information regarding the requested variability.

The enrollment form, election of portability coverage form, evidence of insurability form and supplemental data form will be used with this product. The evidence of insurability form is bracketed for flexibility to support future enhancements to underwriting, based on face amount and age of the proposed insured. The supplemental data form will be used for overflow data from the additional data section on the enrollment and evidence of insurability forms. Form MAPP-DC, Application for Group Insurance, previously approved by your Department is the master application that is used with our group products. It was approved by your Department on 3/13/2013 under SERFF # UNUM-128907549.

An Underwriting Statement of Variability is also included with this filing and provides a more detailed explanation about the brackets within the evidence of insurability form. Enrollment methods include agent-assisted situations, in person or via call centers and self-enrolled situations, using paper or electronic application processes, such as web-based. Electronic application processes may also be used in agent-assisted situations.

A separate rate filing has been submitted under SERFF# UNUM-132106301.

These forms have been submitted to our domicile state, South Carolina.

We reserve the right to alter the layout of these forms including ordering of the provision, color, typeface and font and to change variables as requested by a specific employer to accommodate future product design needs as long as such changes are in compliance with your state law without re-filing due to future technology changes (i.e. paper size, font, page numbers, ordering of the provisions, line ending or page ending changes). Any minimum font-size requirements will be in compliance with your state law. We also reserve the right to use these forms in an electronic format and certify that we will retain the approved final print format.

Thank you for your consideration. If acceptable, we shall appreciate your notifying us via SERFF. If you have any questions, please contact me at (800) 845-7330, extension 82962. My email address is blwessinger@coloniallife.com. The fax number is (803) 750-7341.

Sincerely,

Brandi Wessinger
Product Compliance Consultant

State: *District of Columbia* ***Filing Company:*** *Colonial Life & Accident Insurance Company*
TOI/Sub-TOI: *H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*
Product Name: *Group Critical Illness/Cancer*
Project Name/Number: *Group Critical Illness/Cancer /GCI6000*

Company and Contact

Filing Contact Information

Brandi Wessinger, Product Compliance Consultant II
1200 Colonial Life Boulevard
Columbia, SC 29202

blwessinger@coloniallife.com

803-678-2962 [Phone]

Filing Company Information

Colonial Life & Accident Insurance Company
1200 Colonial Life Boulevard
Post Office Box 1365
Columbia, SC 29202
(803) 798-7000 ext. [Phone]

CoCode: 62049
Group Code: 565
Group Name:
FEIN Number: 57-0144607

State of Domicile: South Carolina
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*UNUM-132106302*	***State Tracking #:***		***Company Tracking #:***	*GCI6000 - FORMS*

State:	*District of Columbia*	***Filing Company:***	*Colonial Life & Accident Insurance Company*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*Group Critical Illness/Cancer*		
Project Name/Number:	*Group Critical Illness/Cancer /GCI6000*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
APPROVED	Colin Johnson	02/06/2020	02/06/2020

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Colin Johnson	02/05/2020	02/05/2020
Pending Industry Response	Colin Johnson	02/05/2020	02/05/2020
Pending Industry Response	Colin Johnson	02/04/2020	02/04/2020
Pending Industry Response	Colin Johnson	01/31/2020	01/31/2020

Response Letters

Responded By	Created On	Date Submitted
Brandi Wessinger	02/06/2020	02/06/2020
Brandi Wessinger	02/06/2020	02/06/2020
Brandi Wessinger	02/06/2020	02/06/2020
Brandi Wessinger	02/06/2020	02/06/2020

SERFF Tracking #:	*UNUM-132106302*	***State Tracking #:***		***Company Tracking #:***	*GCI6000 - FORMS*

State:	*District of Columbia*	***Filing Company:***	*Colonial Life & Accident Insurance Company*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*Group Critical Illness/Cancer*		
Project Name/Number:	*Group Critical Illness/Cancer /GCI6000*		

Disposition

Disposition Date: 02/06/2020

Implementation Date: 02/06/2020

Status: APPROVED

Comment: Rates for this filing have been filed under SERFF # UNUM-132106302.

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Colonial Life & Accident Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Statements of Variability	APPROVED	Yes
Supporting Document (revised)	Readability Certification	APPROVED	Yes
Supporting Document	Readability Certification	Withdrawn	Yes
Supporting Document	DC Guaranty Notice	APPROVED	Yes
Supporting Document	Cover Letter	APPROVED	Yes
Supporting Document	2/6/2020 Resubmission Letter	APPROVED	Yes
Form (revised)	Group Specified Disease Master Policy	APPROVED	Yes
Form	Group Specified Disease Master Policy	Withdrawn	No
Form (revised)	Group Specified Disease Certificate	APPROVED	Yes
Form	Group Specified Disease Certificate	Withdrawn	No
Form (revised)	Group Cancer Benefits Rider	APPROVED	Yes
Form	Group Cancer Benefits Rider	Withdrawn	No
Form	Group First Diagnosis Building Benefit Rider	APPROVED	Yes
Form	Group Heart Benefits Rider	APPROVED	Yes
Form	Group Infectious Diseases Rider	APPROVED	Yes
Form	Group Progressive Diseases Rider	APPROVED	Yes
Form	Election of Group Specified Disease Insurance Portability Coverage	APPROVED	Yes
Form	Group Specified Disease Insurance Enrollment Form	APPROVED	Yes

SERFF Tracking #:	*UNUM-132106302*	***State Tracking #:***		***Company Tracking #:***	*GCI6000 - FORMS*

State:	*District of Columbia*	***Filing Company:***	*Colonial Life & Accident Insurance Company*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*Group Critical Illness/Cancer*		
Project Name/Number:	*Group Critical Illness/Cancer /GCI6000*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Group Specified Disease Insurance Evidence of Insurability Form	APPROVED	Yes
Form	Group Specified Disease Supplemental Data Form	APPROVED	Yes

State: *District of Columbia* **Filing Company:** *Colonial Life & Accident Insurance Company*
TOI/Sub-TOI: *H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*
Product Name: *Group Critical Illness/Cancer*
Project Name/Number: *Group Critical Illness/Cancer /GCI6000*

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	02/05/2020
Submitted Date	02/05/2020
Respond By Date	02/12/2020

Dear Brandi Wessinger,

Introduction:

Please review D.C. Statute 31-4712 c(1)(H) and include your "Time of Payment of Claims" language provision by stating " will be paid immediately upon receipt of due written proof of such law."

Conclusion:

Sincerely,
Colin Johnson

State: *District of Columbia* **Filing Company:** *Colonial Life & Accident Insurance Company*
TOI/Sub-TOI: *H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*
Product Name: *Group Critical Illness/Cancer*
Project Name/Number: *Group Critical Illness/Cancer /GCI6000*

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	02/05/2020
Submitted Date	02/05/2020
Respond By Date	02/12/2020

Dear Brandi Wessinger,

Introduction:

Review the D.C. § 31-4712 2(I) and include the Conformity with State Statutes provision Specifically, insert the following provision:
"Any provision in this Policy that is in conflict with the requirements of any state and/or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws."

Please update your records by deleting Stephen Taylor's name under the DISB address below for your external appeal process language:

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non -Medical Necessity cases,
Commissioner , Department of Insurance, Securities and Banking
1050 First St. N.E., Suite 801
Washington, D.C. 20002
202-727-8000
Fax: (202) 354-1085

Also amend the District of Columbia Department of Health Care Finance , Office of the Health Care Ombudsman and Bill of Rights ' address by inserting " Suite" in its address. As a result, the company's address in question should read
441 4th St. N.W., Suite 900 South , Washington, D.C. 20001
1 (877) 685-6391, (202) 724-7491, Fax: (202) 442- 6724

Conclusion:

Sincerely,
Colin Johnson

State: *District of Columbia* **Filing Company:** *Colonial Life & Accident Insurance Company*
TOI/Sub-TOI: *H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*
Product Name: *Group Critical Illness/Cancer*
Project Name/Number: *Group Critical Illness/Cancer /GCI6000*

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	02/04/2020
Submitted Date	02/04/2020
Respond By Date	02/12/2020

Dear Brandi Wessinger,

Introduction:

Amend your "spouse" definition by inserting , " Whenever the term Spouse appears in the Policy, this provision includes the definition of domestic partner and civil union partner into the Policy / Certificate."

Our Departmental policy does not allow mandates or definitions to be bracketed. Only percentages, dates, number of days, and dollar amounts within the mandate provisions and definitions are allowed to be bracketed.

Instead, please DELETE THE OPEN AND CLOSED brackets and substitute the brackets with a text box (border) around all the definitions and mandates that are variable or delete the brackets. This includes all definitions within your policy , rider and certificate.

Please review Jury and Marriage Amendment Act of 2009 and amend your " Family Member" definition to include the following: “civil union partner."

Review our bulletin number 01-IB-007-02/08 dated February 8, 2002, “Limited Benefit Alert” and insert, “Limited Benefit, Please Read Carefully” on the face (first) page on these types of policies, certificates, riders, amendments, and endorsements.

Please review our D.C. 31-4725 & 31-4726 (flesch reading score) and include your certificate readability score on your forms not withstanding, applications, policies, certificates, amendments, riders, enrollments, evidence of insurability form, and endorsements. This includes items # 8 - # 11.

Please confirm if your corresponding rate filing has been submitted to our Department.

Conclusion:

Sincerely,
Colin Johnson

State: District of Columbia **Filing Company:** Colonial Life & Accident Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Group Critical Illness/Cancer
Project Name/Number: Group Critical Illness/Cancer /GCI6000

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/31/2020
Submitted Date	01/31/2020
Respond By Date	02/10/2020

Dear Brandi Wessinger,

Introduction:

Please update your records and include the contact name below for your external appeal process language by deleting "Stephen C. Taylor."

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non -Medical Necessity cases,
Commissioner ,Department of Insurance, Securities and Banking
1050 First St. N.E., Suite 801
Washington, D.C. 20002
202-727-8000
Fax: (202) 354-1085

Amend the District of Columbia Department of Health Care Finance , Office of the Health Care Ombudsman and Bill of Rights ' address by inserting " Suite" in its address. As a result, the company's address in question should read
441 4th St. N.W., Suite 900 South , Washington, D.C. 20001
1 (877) 685-6391, (202) 724-7491, Fax: (202) 442- 6724

Review our bulletin number 01-IB-007-02/08 dated February 8, 2002, "Limited Benefit Alert" and insert, "Limited Benefit, Please Read Carefully" on the face page on these type of policies, certificates, riders, amendments, and endorsements.

Please review D.C. Statute 31-4712 c(1)(H) and include your "Time of Payment of Claims" language provision by stating " will be paid immediately upon receipt of due written proof of such law."

Our Departmental policy does not allow mandates or definitions to be bracketed. Only percentages, dates, number of days, and dollar amounts within the mandate provisions and definitions.

Instead, substitute the bracket with a text box (border) around your definitions ad mandates. You have the option of displaying a copy of the text boxes within the supporting documentation tab.

In our jurisdiction, spouse is not equated to a registered domestic partner or civil union partner. Therefore, please amend the spouse definition to " whenever the term Spouse appears in the Policy, this provision includes the Definition of registered domestic partner and civil union partner into the Policy."

Please confirm if your corresponding rate filing has been submitted to our Department.

Conclusion:

Sincerely,

State:	District of Columbia	**Filing Company:**	Colonial Life & Accident Insurance Company
TOI/Sub-TOI:	H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness		
Product Name:	Group Critical Illness/Cancer		
Project Name/Number:	Group Critical Illness/Cancer /GCI6000		

Colin Johnson

State: District of Columbia **Filing Company:** Colonial Life & Accident Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Group Critical Illness/Cancer
Project Name/Number: Group Critical Illness/Cancer /GCI6000

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	02/06/2020
Submitted Date	02/06/2020

Dear Colin Johnson,

Introduction:

This is in response to your objection letter dated 2/5/2020.

Response 1

Comments:

I've combined our responses for all objections into one letter. Some objections were duplicates so I did not include them twice.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your continued review of this filing.

Sincerely,

Brandi Wessinger

State: District of Columbia **Filing Company:** Colonial Life & Accident Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Group Critical Illness/Cancer
Project Name/Number: Group Critical Illness/Cancer /GCI6000

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	02/06/2020
Submitted Date	02/06/2020

Dear Colin Johnson,

Introduction:

This is in response to your objection letter dated 2/5/2020.

Response 1

Comments:

I've combined our responses for all objections into one letter. Some objections were duplicates so I did not include them twice.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your continued review of this filing.

Sincerely,

Brandi Wessinger

State: District of Columbia **Filing Company:** Colonial Life & Accident Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Group Critical Illness/Cancer
Project Name/Number: Group Critical Illness/Cancer /GCI6000

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	02/06/2020
Submitted Date	02/06/2020

Dear Colin Johnson,

Introduction:

This is in response to your objection letter received on 2/4/2020.

Response 1

Comments:

I've combined our responses for all objections into one letter. Some objections were duplicates so I did not include them twice.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your continued review of this filing.

Sincerely,

Brandi Wessinger

SERFF Tracking #:	*UNUM-132106302*	***State Tracking #:***		***Company Tracking #:***	*GCI6000 - FORMS*

State:	*District of Columbia*	***Filing Company:***	*Colonial Life & Accident Insurance Company*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*Group Critical Illness/Cancer*		
Project Name/Number:	*Group Critical Illness/Cancer /GCI6000*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	02/06/2020
Submitted Date	02/06/2020

Dear Colin Johnson,

Introduction:

This is in response to your objection letter dated 1/31/2020.

Response 1

Comments:

I've combined our responses for all objections into one letter. Some objections were duplicates so I did not include them twice.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Readability Compliance Certification - DC - Completed.pdf
Previous Version	
Satisfied - Item:	*Readability Certification*
Comments:	
Attachment(s):	*Readability Compliance Certification - DC.pdf*

SERFF Tracking #:	*UNUM-132106302*	***State Tracking #:***		***Company Tracking #:***	*GCI6000 - FORMS*

State:	*District of Columbia*	***Filing Company:***	*Colonial Life & Accident Insurance Company*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*Group Critical Illness/Cancer*		
Project Name/Number:	*Group Critical Illness/Cancer /GCI6000*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Readability Compliance Certification - DC - Completed.pdf
Previous Version	
Satisfied - Item:	*Readability Certification*
Comments:	
Attachment(s):	*Readability Compliance Certification - DC.pdf*

Satisfied - Item:	2/6/2020 Resubmission Letter
Comments:	
Attachment(s):	GCI6000-DC 1.31.2020 Resubmission Letter.pdf

SERFF Tracking #: UNUM-132106302 **State Tracking #:** **Company Tracking #:** GCI6000 - FORMS

State: District of Columbia **Filing Company:** Colonial Life & Accident Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Group Critical Illness/Cancer
Project Name/Number: Group Critical Illness/Cancer /GCI6000

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Group Specified Disease Master Policy	GCI6000-P	POLA	Initial		52.100	GCI6000-P-DC.pdf	Date Submitted: 02/06/2020 By: Brandi Wessinger
Previous Version								
1	*Group Specified Disease Master Policy*	*GCI6000-P*	*POLA*	*Initial*		*52.100*	*GCI6000-P.pdf*	*Date Submitted: 01/13/2020 By: Brandi Wessinger*
2	Group Specified Disease Certificate	GCI6000-C-DC	CER	Initial		51.800	GCI6000-C-DC.pdf	Date Submitted: 02/06/2020 By: Brandi Wessinger
Previous Version								
2	*Group Specified Disease Certificate*	*GCI6000-C-DC*	*CER*	*Initial*		*51.800*	*GCI6000-C-DC.pdf*	*Date Submitted: 01/13/2020 By: Brandi Wessinger*
3	Group Cancer Benefits Rider	R-GCI6000-CB	POLA	Initial		50.600	R-GCI6000-CB-DC.pdf	Date Submitted: 02/06/2020 By: Brandi Wessinger
Previous Version								
3	*Group Cancer Benefits Rider*	*R-GCI6000-CB*	*POLA*	*Initial*		*50.600*	*R-GCI6000-CB.pdf*	*Date Submitted: 01/13/2020 By: Brandi Wessinger*

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your continued review of this filing.

Sincerely,

Brandi Wessinger

SERFF Tracking #:	*UNUM-132106302*	***State Tracking #:***		***Company Tracking #:***	*GCI6000 - FORMS*

State:	*District of Columbia*	***Filing Company:***	*Colonial Life & Accident Insurance Company*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*Group Critical Illness/Cancer*		
Project Name/Number:	*Group Critical Illness/Cancer /GCI6000*		

Form Schedule

Lead Form Number: GCI6000-P

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	APPROVED 02/06/2020	Group Specified Disease Master Policy	GCI6000-P	POLA	Initial		52.100	GCI6000-P-DC.pdf
2	APPROVED 02/06/2020	Group Specified Disease Certificate	GCI6000-C-DC	CER	Initial		51.800	GCI6000-C-DC.pdf
3	APPROVED 02/06/2020	Group Cancer Benefits Rider	R-GCI6000-CB	POLA	Initial		50.600	R-GCI6000-CB-DC.pdf
4	APPROVED 02/06/2020	Group First Diagnosis Building Benefit Rider	R-GCI6000-BB	POLA	Initial		50.300	R-GCI6000-BB.pdf
5	APPROVED 02/06/2020	Group Heart Benefits Rider	R-GCI6000-HB-DC	POLA	Initial		50.600	R-GCI6000-HB-DC.pdf
6	APPROVED 02/06/2020	Group Infectious Diseases Rider	R-GCI6000-INF-DC	POLA	Initial		50.400	R-GCI6000-INF-DC.pdf
7	APPROVED 02/06/2020	Group Progressive Diseases Rider	R-GCI6000-PD-DC	POLA	Initial		50.700	R-GCI6000-PD-DC.pdf
8	APPROVED 02/06/2020	Election of Group Specified Disease Insurance Portability Coverage	GCI6000 Port-DC	AEF	Initial			GCI Port form DC 83340 John Doe.pdf
9	APPROVED 02/06/2020	Group Specified Disease Insurance Enrollment Form	GCI6000 Enroll-DC	AEF	Initial			GCI Enrollment form DC 83337 John Doe.pdf
10	APPROVED 02/06/2020	Group Specified Disease Insurance Evidence of Insurability Form	GCI6000 E of I-DC	AEF	Initial			GCI E of I form DC 83338 John Doe.pdf
11	APPROVED 02/06/2020	Group Specified Disease Supplemental Data Form	GCI6000SD 19	AEF	Initial			Supplemental Data Form 19 Reg 83365 John Doe.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider

State: District of Columbia **Filing Company:** Colonial Life & Accident Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Group Critical Illness/Cancer
Project Name/Number: Group Critical Illness/Cancer /GCI6000

DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NAP**	Network Access Plan
NOC	Notice of Coverage	**OTH**	Other
OUT	Outline of Coverage	**PJK**	Policy Jacket
POL	Policy/Contract/Fraternal Certificate	**POLA**	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider
PRC	Provider Contract/Provider Addendum/Provider Leading Agreement	**PRD**	Provider Directory

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

[1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com]
A Stock Company

GROUP [CRITICAL ILLNESS] [AND] [CANCER] SPECIFIED DISEASE INSURANCE POLICY

THIS IS A NON-PARTICIPATING POLICY THAT PROVIDES LIMITED BENEFITS. [THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. [LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.]]

Please Read This Policy Carefully
This policy is a legal contract between the policyholder and us. To understand the coverage, this policy must be read as a whole. This policy describes the provisions with which the Policyholder should be familiar. Please see the certificate for specific details on the benefits.

Throughout this policy, the word **policyholder** refers to the organization shown on the Policy Rate Schedule. **You** or **your** refers to a named insured who is covered under this coverage. **Named insured** refers to the person who is a member of an eligible class as described on the Policy Rate Schedule, who holds a certificate of coverage and for whom the policyholder remits premium. **Covered person** refers to any person covered under this policy as described on the Certificate Schedule. **We, us, our** or **company** refer to Colonial Life & Accident Insurance Company.

[This policy is delivered in and is governed by the laws of the governing jurisdiction shown on the Policy Rate Schedule and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.]

This policy is issued in consideration of the application of the policyholder, a copy of which is attached to and made a part of this policy, and the payment of premium when due. This policy takes effect at 12:01 a.m. Standard Time at the policyholder's address on the Policy Effective Date shown on the Policy Rate Schedule.

We agree to pay, in accordance with the terms of this policy, the benefit amounts of the policy to the named insureds. Benefit details are shown in the certificate.

Right to Return This Policy
If, for any reason, you are not satisfied with this policy, you can return it to us at our home office within 30 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider this policy as if it never existed. Any premium paid will be refunded.

Signed for Colonial Life & Accident Insurance Company:
[

Secretary

President and Chief Executive Officer]

THIS IS A LIMITED POLICY.
PLEASE READ IT CAREFULLY.

THE POLICY IS CANCELLABLE AT THE OPTION OF THE COMPANY.
PLEASE READ THE "TERMINATION OF THIS CONTRACT" PROVISION.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

SECTION 2 – POLICY GUIDE

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

POLICY RATE SCHEDULE

Policyholder:	[ABC Employer]	Policy Number:	[987654321]
Policyholder Address:	[123 Any Street Attn: Any Town, SC 99999-9999]	Billing Control Number:	[E123456]
Policy Effective Date:	[01/01/2022]	Governing Jurisdiction:	[Any State]
First Policy Anniversary:	[01/01/2023]		

Description of Eligible Classes
[All employees in active employment with the policyholder working a minimum of [20] hours per week. Temporary and seasonal workers are excluded from coverage.

Active Employment means the named insured is working for the policyholder at the worksite for earnings that are paid regularly, and is performing the material and substantial duties of their regular occupation. The named insured will not be considered in active employment if employment status is being continued under a severance or termination agreement. The worksite must be:

- the policyholder's usual place of business;
- an alternative work site at the direction of the policyholder; or
- a location to which the named insured's job requires travel.

Material and Substantial Duties means duties that are normally required for the performance of the named insured's regular occupation and cannot be reasonably omitted or modified.

Regular Occupation means the occupation the named insured routinely performs on the job.]

New Hire Waiting Period: [90] days

New Hire Eligibility Period: [31] days

A member of an eligible class chooses from the following options:

BENEFIT AMOUNT:		**Face Amount**
Face Amount for Named Insured	Amount selected by the named insured	[$1,000 - $150,000]
[Face Amount for Spouse	[50 - 100]% of the named insured benefit amount	[$500 - $150,000]]
[Face Amount for Dependent Children	[50 - 200]% of the named insured benefit amount	[$500 - $300,000]]

[In addition, a member of an eligible class may choose to purchase additional Face Amount for Named Insured in $1,000 increments, up to a maximum Face Amount of [$150,000].]

[POLICYHOLDER PLAN CHOICE FOR CRITICAL ILLNESS BENEFIT:

COVERED CONDITIONS:
Benign Brain Tumor, Coma, Coronary Artery Disease, End Stage Renal (Kidney) Failure, Heart Attack (Myocardial Infarction), Loss of Hearing, Loss of Sight, Loss of Speech, Major Organ Failure Requiring Transplant, Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D, Permanent Paralysis Due to a Covered Accident, Stroke, Sudden Cardiac Arrest.

Benefit Payable Upon Subsequent Diagnosis of a Critical Illness]

[POLICYHOLDER PLAN CHOICE FOR ADDITIONAL CRITICAL ILLNESS BENEFIT FOR DEPENDENT CHILDREN:

ADDITIONAL CRITICAL ILLNESS BENEFIT FOR DEPENDENT CHILDREN
COVERED CONDITIONS:
Cerebral Palsy, Cleft Lip or Palate, Cystic Fibrosis, Down Syndrome, Spina Bifida]

[POLICYHOLDER PLAN CHOICE FOR CANCER BENEFITS:

DIAGNOSIS OF CANCER BENEFITS:
Invasive Cancer (Including all Breast Cancer) and Non-Invasive Cancer

Benefit Payable Upon Reoccurrence of Invasive Cancer (Including all Breast Cancer)

Skin Cancer Initial Diagnosis]

[Policyholder Plan Choice for Wellbeing Assistance Benefit:

Wellbeing Assistance Benefit
Wellbeing Assistance Benefit of [$25]]

[Riders:
[Cancer Benefits Rider]
[First Diagnosis Building Benefit Rider]
[Heart Benefits Rider]
[Infectious Diseases Rider]
[Progressive Diseases Rider]]

Initial Monthly Rates per Unit for [Critical Illness Benefit] [,] [Additional Critical Illness Benefit for Dependent Children] [and] [Invasive Cancer Benefit (Including all Breast Cancer), Non-Invasive Cancer Benefit and Skin Cancer Initial Diagnosis Benefit]:
[

Initial Monthly Rates per Unit				
Age Band	**[Non-Tobacco] [Uni-Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates per Unit				
Age Band	**[Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates per Unit				
[Attained] Age Band	**[Non-Tobacco] [Uni-Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-24	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
25-29	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
30-34	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
35-39	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
40-44	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
45-49	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
50-54	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
55-59	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

60-64	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
65-69	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
70-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates per Unit				
[Attained] Age Band	**[Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-24	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
25-29	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
30-34	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
35-39	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
40-44	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
45-49	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
50-54	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
55-59	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
60-64	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
65-69	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
70-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[The method required to calculate premium for a covered person uses Attained Age rates. This method will apply for the duration of the policy. Attained Age rates are rates that increase as a covered person ages and moves into a new age band.]

[The method required to calculate premium for a covered person uses Issue Age rates. This method will apply for the duration of the policy. Issue Age rates are rates that reflect a covered person's age at the time of purchase.]

[Initial Monthly Rates for Wellbeing Assistance Benefit

Initial Monthly Rates for Wellbeing Assistance Benefit				
Age Band				
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[Initial Monthly Rates for Cancer Benefits Rider

[

Initial Monthly Rates for Cancer Benefits Rider [Level 1]				
Age Band	**[Non-Tobacco] [Uni-Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for Cancer Benefits Rider [Level 1]				
Age Band	**[Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for Cancer Benefits Rider [Level 1]				
[Issue] Age Band	[Non-Tobacco] [Uni-Tobacco]			
	[Named Insured]	[Named Insured and Spouse]	[One-Parent Family]	[Two-Parent Family]
[16-24	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
25-29	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
30-34	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
35-39	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
40-44	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
45-49	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
50-54	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
55-59	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
60-64	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
65-69	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
70-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for Cancer Benefits Rider [Level 1]				
[Issue] Age Band	[Tobacco]			
	[Named Insured]	[Named Insured and Spouse]	[One-Parent Family]	[Two-Parent Family]
[16-24	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
25-29	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
30-34	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
35-39	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
40-44	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
45-49	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
50-54	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
55-59	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
60-64	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
65-69	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
70-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]]

[Initial Monthly Rates for First Diagnosis Building Benefit Rider

[

Initial Monthly Rates for First Diagnosis Building Benefit Rider				
Age Band	[Non-Tobacco] [Uni-Tobacco]			
	[Named Insured]	[Named Insured and Spouse]	[One-Parent Family]	[Two-Parent Family]
[16-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for First Diagnosis Building Benefit Rider				
Age Band	[Tobacco]			
	[Named Insured]	[Named Insured and Spouse]	[One-Parent Family]	[Two-Parent Family]
[16-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for First Diagnosis Building Benefit Rider				
[Issue] Age Band	**[Non-Tobacco] [Uni-Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-24	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
25-29	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
30-34	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
35-39	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
40-44	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
45-49	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
50-54	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
55-59	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
60-64	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
65-69	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
70-74	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for First Diagnosis Building Benefit Rider				
[Issue] Age Band	**[Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-24	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
25-29	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
30-34	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
35-39	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
40-44	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
45-49	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
50-54	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
55-59	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
60-64	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
65-69	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
70-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]]

[Initial Monthly Rates for Heart Benefits Rider

[

Initial Monthly Rates for Heart Benefits Rider				
Age Band	**[Non-Tobacco] [Uni-Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for Heart Benefits Rider				
Age Band	**[Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for Heart Benefits Rider				
[Issue] Age Band	**[Non-Tobacco] [Uni-Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-24	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
25-29	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
30-34	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
35-39	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
40-44	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
45-49	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
50-54	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
55-59	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
60-64	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
65-69	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
70-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for Heart Benefits Rider				
[Issue] Age Band	**[Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-24	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
25-29	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
30-34	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
35-39	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
40-44	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
45-49	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
50-54	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
55-59	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
60-64	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
65-69	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
70-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]]

[Initial Monthly Rates for Infectious Diseases Rider

[

Initial Monthly Rates for Infectious Diseases Rider				
Age Band				
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for Infectious Diseases Rider				
[Issue] Age Band	**[Non-Tobacco] [Uni-Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-24	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
25-29	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
30-34	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
35-39	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

40-44	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
45-49	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
50-54	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
55-59	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
60-64	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
65-69	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
70-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for Infectious Diseases Rider				
[Issue] Age Band	**[Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-24	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
25-29	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
30-34	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
35-39	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
40-44	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
45-49	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
50-54	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
55-59	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
60-64	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
65-69	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
70-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]]

[Initial Monthly Rates for Progressive Diseases Rider

[

Initial Monthly Rates for Progressive Diseases Rider				
Age Band				
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for Progressive Diseases Rider				
[Issue] Age Band	**[Non-Tobacco] [Uni-Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-24	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
25-29	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
30-34	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
35-39	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
40-44	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
45-49	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
50-54	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
55-59	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
60-64	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
65-69	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
70-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]

[

Initial Monthly Rates for Progressive Diseases Rider				
[Issue] Age Band	**[Tobacco]**			
	[Named Insured]	**[Named Insured and Spouse]**	**[One-Parent Family]**	**[Two-Parent Family]**
[16-24	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
25-29	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
30-34	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
35-39	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
40-44	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
45-49	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
50-54	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
55-59	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
60-64	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
65-69	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]
70-74]	$[XX.XX]	$[XX.XX]	$[XX.XX]	$[XX.XX]

]]

Unit means $1,000 of Face Amount for named insured.

Additional Services: This policy may include enrollment, risk management, financial protection and other support services related to the policyholder's benefit program.

Rate Guarantee Period: A change in the premium rate table(s) will not take effect before [one year] after the policy effective date.

[**Divisions, subsidiaries or affiliated companies include:**
Name/location (city and state)]

SECTION 4 - POLICYHOLDER PROVISIONS

Ownership
The policyholder is the owner of this policy and may agree with us to change it without the consent of or notice to the covered persons or their assignees.

Entire Contract
The entire contract consists of:
- this policy;
- the application of the policyholder attached to this policy;
- each named insured's enrollment form and evidence of insurability, if applicable;
- certificates issued under this policy; and
- riders, endorsements or amendments to the policy or certificates.

Changes to the Contract
This policy may be changed in whole or in part. Riders, endorsements and amendments add provisions to or change the terms of this policy.

Any changes to this policy, other than a change in the premium we charge, must be in writing and evidenced by endorsement on this policy, or by amendment to this policy signed by the policyholder and one of our executive officers at our home office. No agent or anyone else can change this policy or waive any of its provisions.

Furnishing Certificates
The company will provide a certificate for each named insured. The certificate will provide a description of the insurance provided by this policy and will state:
- the benefits provided under this policy;
- to whom benefits are payable;
- the limitations, exclusions and requirements that apply to coverage under this policy; and
- how to file a claim against the coverage.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy will govern.

Contestability
During the first two years from the policy effective date, if any intentional or unintentional misstatements are made by the policyholder in the application to obtain this policy, we can, at our sole discretion:
- void the policy;
- deny a claim for loss; and/or
- use the facts to decide whether the covered person has coverage, in what amounts, and make applicable premium adjustments.

In the event of fraud, however, we can at any time void the policy, deny a claim for loss, and/or take legal action as permitted by applicable law.

Conformity with State Statutes
Any provision in this Policy that is in conflict with the requirements of any state and/or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Our Right to Change Premiums
We have the right to change the premium we charge after notifying the policyholder in writing at least [45] days in advance.

A change in the initial monthly rates will not take effect before the end of the rate guarantee period shown on the Policy Rate Schedule except for reasons which affect the risk assumed, including, but not limited to:
- a change occurs in this policy;
- a division, subsidiary, or affiliated company is added or deleted;
- the number of insureds changes by 25% or more; or
- a new law, a change in any existing law or regulatory process is enacted that substantially impacts this policy, the benefits payable or the risk insured.

After the rate guarantee period, we can change premium rates at any time. A change may take effect on an earlier date when both we and the policyholder agree in writing.

New Hires
Members of an eligible class, as described on the Policy Rate Schedule, will become insured when they satisfy the requirements defined in the certificate.

Enrollment
An individual who is a member of an eligible class may enroll in coverage during the eligibility period, as shown on the Policy Rate Schedule, that follows the later of:

- the policy effective date as shown on the Policy Rate Schedule;
- the date the individual first becomes a member of an eligible class;
- the date the individual completes the policyholder probationary period shown on the application of the policyholder, if applicable; or
- the date the individual meets evidence of insurability requirements, if any.

A **late entrant** is an individual who fails to enroll during the initial product offering, the new hire eligibility period or has voluntarily cancelled previous coverage and is reapplying. A late entrant may only apply during an open enrollment period with evidence of insurability. The policyholder and the company will determine when an open enrollment period begins and ends.

After the coverage effective date, the named insured cannot make any changes to the coverage type under this certificate until an open enrollment period, unless the named insured has a qualifying event. A **qualifying event,** for the purposes of this provision, means:

- birth or adoption of a child;
- issuance of a court order requiring coverage of a child;
- marriage;
- divorce; or
- death of a covered person.

The named insured will have 31 days from the date of occurrence of a qualifying event in which to:

- notify us they wish to make a change;
- complete any required enrollment form; and
- pay any additional premium, if applicable.

Information to be Furnished by the Policyholder
The policyholder must keep a record of the named insureds and the particulars of the insurance on each and their covered spouse and dependent children, if applicable. As changes occur, the policyholder should provide us, on forms acceptable to us, information relative to any persons:

- who are eligible to enroll;
- who are insured by the coverage;
- whose amounts of coverage change;
- whose status changes and any other information that may be required to manage a claim ; and/or
- whose coverage terminates pursuant to the “Termination of Insurance” provision in the certificate.

The policyholder should also provide us with any other information about the coverage that may be reasonably required, such as named insureds on leave of absence, including named insureds who are on leave under the Family and Medical Leave Act.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time. We may inspect these records at any time while this policy is in force and within one year after the termination of this policy.

All statements made in any application are considered representations and not warranties (absolute guarantees). No representation by the policyholder in applying for insurance under this policy will make it void unless the representation is contained in the application of the policyholder.

Clerical Error or Omission
Clerical error or omission by us will not:

- prevent a covered person from receiving coverage;

- affect the amount of a covered person's coverage;
- cause a covered person's coverage to begin or continue when the coverage would not otherwise be effective; or
- reinstate coverage that validly ended.

Electronic Transactions
Any transaction relating to this policy may be conducted by electronic means if performance of the transaction is consistent with applicable state and federal law. Any notice required by the provisions of this policy given by written, electronic and telephonic, as applicable, means will have the same force and effect as notice given in writing.

SECTION 5 – PREMIUM PAYMENTS

Premium Payments
The initial premium for each type of coverage under this policy is based on the initial monthly rates shown on the Policy Rate Schedule.

Premium Amount
To ensure accurate premium calculations, the policyholder is responsible for reporting to us the following information during the stated time periods:
- individuals who are eligible to enroll are to be reported during the month prior to or during the month the coverage becomes effective;
- covered persons whose coverage has terminated are to be reported within a month of the date coverage terminated; and
- changes in named insureds' class are to be reported within a month of the date that the change in insurance class took place.

When and Where to Pay Premiums
The premiums for each certificate must be paid in United States dollars, to our home office, when they are due.

The premium due dates are based on:
- the coverage effective dates shown on the Certificate Schedule; and
- the premium frequency.

The premium frequency is how often the premiums are paid. The policyholder will be liable to us for all unpaid premiums for any period, including the grace period, during which coverage under this policy was in force as to any covered person. Premium increases or decreases which take effect during an insurance month are due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Grace Period (If Premiums Are Not Paid When Due)
After the first premium, if the premium is not paid when it is due, it can be paid during the next 31 days. These 31 days are called the grace period. During the grace period this policy will remain in force, unless we receive written notice from the policyholder to cancel this policy. The policyholder is liable for premium due during the grace period and must pay us all premium due for the full period this policy is in force. If the premium is not paid before the grace period ends, the coverage provided by this policy will terminate at the end of the grace period.

SECTION 6 – TERMINATION

Termination of This Contract
This policy can be terminated:
- by the policyholder; or
- by us.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. This policy can be cancelled on an earlier date if we and the policyholder both agree. Coverage will end at 12:00 midnight Standard Time at the policyholder's address on the cancellation date.

We may cancel or modify this policy if:
- our participation requirements are not met, as applicable;

- the policyholder does not promptly provide us with information that is reasonably required;
- the policyholder fails to perform any of its obligations that relate to this policy;
- the premium is not paid in accordance with the provisions of this policy that specify whether the policyholder or the named insured pays the premiums;
- the policyholder does not promptly report to us the required information about any named insureds who are added or removed from an eligible group;
- we determine that there is a significant change in the policyholder or named insureds as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization that impacts the size, occupation, or age of any eligible groups;
- we provide the policyholder with [45] days written notice at any time after any rate guarantee period for any reason; or
- any change occurs in federal or state law, regulation, or regulatory process that substantially impacts this policy, the benefits payable, or the risk insured.

If we cancel this policy for reasons other than the policyholder's failure to remit premium, a written notice will be delivered to the policyholder by mail at least 60 days prior to the cancellation date.

If this policy is cancelled, the cancellation will not affect a claim for which we are liable under the terms of this policy.

Policyholder Responsibility to Named Insureds
If this policy terminates for any reason, the policyholder must:
- notify each named insured of the effective date of the termination; and
- refund or otherwise account to each named insured all contributions received or withheld from them for premiums not actually paid to us.

Workers' Compensation
This policy is not in lieu of, and does not affect, any requirement for coverage by workers' compensation insurance.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

[1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com]
A Stock Company

GROUP [CRITICAL ILLNESS] [AND] [CANCER] SPECIFIED DISEASE INSURANCE CERTIFICATE

THIS CERTIFICATE EXPLAINS THE BENEFITS PROVIDED UNDER THE GROUP [CRITICAL ILLNESS] [AND] [CANCER] SPECIFIED DISEASE INSURANCE POLICY. THIS IS A NON-PARTICIPATING CERTIFICATE THAT PROVIDES LIMITED BENEFITS. [THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. [LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.]]

Please Read This Certificate Carefully
This is your certificate of coverage as long as you are insured under the policy. You will want to read it carefully and keep it in a safe place. This certificate describes your benefits in detail. This certificate contains certain proof of loss requirements, limitations, exclusions, and other provisions that may reduce benefits or prevent an insured from receiving benefits under this certificate.

Throughout this certificate, the word **you** or **your** refers to the named insured shown on the Certificate Schedule, who is a member of an eligible class as described on the Policy Rate Schedule, who holds a certificate of coverage and for whom premiums are remitted. **Covered person** refers to any person covered under the policy as described on the Certificate Schedule. ***We, us, our*** or **company** refers to Colonial Life & Accident Insurance Company. **Policyholder** refers to the organization shown on the Policy Rate Schedule. It includes any division, subsidiary or affiliated company named in the Policy Rate Schedule. **Policy** means the group contract owned by the policyholder and available for review by you. If the terms of your certificate of coverage and the policy differ, the policy will govern.

The policy and this certificate may be changed in whole or in part or cancelled as stated in the policy. Such an action may be taken without the consent of or notice to any covered person. Only an executive officer at our home office can approve a change. The approval must be in writing and evidenced by endorsement on the policy or certificate or an amendment signed by the policyholder and one of our executive officers at our home office. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes. This certificate replaces any and all certificates previously issued for the eligible classes under the policy.

[The policy and this certificate are delivered in and are governed by the laws of the governing jurisdiction shown on the Policy Rate Schedule and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. Any provision of this certificate of coverage that is in conflict with the applicable state laws of the state in which you reside when you become insured is amended to conform to the minimum requirements of those laws.]

Right to Return This Certificate
If, for any reason, you are not satisfied with this certificate, you can return it to us at our home office within 30 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider this certificate as if it never existed. Any premium paid will be refunded.

Signed for Colonial Life & Accident Insurance Company:
[

Secretary

President and Chief Executive Officer]

Limited benefit, please read this certificate carefully.
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Guide To Health Insurance for People with Medicare available from the company.

SECTION 2 CERTIFICATE GUIDE

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

SECTION 3 – CERTIFICATE SCHEDULE

Policyholder: [ABC Employer]

Certificate Number: [1234567890]

Named Insured: [John Doe]

Billing Control Number: [E1234567]

Coverage
Effective Date: [May 1, 2023]

Premium Class: [Non-Tobacco]

[Pre-existing Condition Limitation Period: 12 months]

Coverage Type: [Named Insured, Named Insured and Spouse, One-Parent Family, Two-Parent Family]

BENEFIT AMOUNT

Face Amount for Named Insured	[$1,000 - $150,000 in $1,000 increments]
[Face Amount for Spouse	[$ 500 - $150,000 in [$ 500] increments]]
[Face Amount for Dependent Children	[$ 500 - $300,000 in [$ 500] increments]]

[BENEFIT FOR CRITICAL ILLNESS

COVERED CONDITIONS:	Percentage of Applicable Face Amount
Benign Brain Tumor	100%
Coma	100%
Coronary Artery Disease	25%
End Stage Renal (Kidney) Failure	100%
Heart Attack (Myocardial Infarction)	100%
Loss of Hearing	100%
Loss of Sight	100%
Loss of Speech	100%
Major Organ Failure Requiring Transplant	100%
Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D	100%
Permanent Paralysis due to a Covered Accident	100%
Stroke	100%
Sudden Cardiac Arrest	100%

Benefit Payable Upon Subsequent Diagnosis of a Critical Illness at 100% of the Face Amount for a *different* critical illness and 25% of the Face Amount for the *same* critical illness when benefit conditions are met as described in this certificate.]

[BENEFIT FOR ADDITIONAL CRITICAL ILLNESS FOR DEPENDENT CHILDREN

COVERED CONDITIONS:	Percentage of Applicable Face Amount
Cerebral Palsy	100%
Cleft Lip or Palate	100%
Cystic Fibrosis	100%
Down Syndrome	100%
Spina Bifida	100%

Maximum Benefit Amount for Additional Critical Illness for Dependent Children: 100% of the Face Amount per covered dependent child per lifetime.]

[BENEFITS FOR CANCER

DIAGNOSIS OF CANCER BENEFITS:	**Percentage of Applicable Face Amount**
Invasive Cancer (Including all Breast Cancer)	100%
Non-Invasive Cancer	25%

Maximum Benefit Amount for Non-Invasive Cancer: 25% of the Face Amount per covered person per lifetime.

Benefit Payable Upon Reoccurrence of Invasive Cancer (Including all Breast Cancer) at 25% of the initial benefit amount for Invasive Cancer (Including all Breast Cancer) when benefit conditions are met as described in this certificate.

Skin Cancer Initial Diagnosis $400 per lifetime
Maximum of one per covered person per lifetime]

[WELLBEING ASSISTANCE BENEFIT

Wellbeing Assistance Benefit [$25 - $300] per day
Maximum of one day per covered person per calendar year. Subject to the waiting period.]

SECTION 4 – GENERAL DEFINITIONS

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

Calendar Year means the period beginning on the coverage effective date shown on the Certificate Schedule and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Child or Dependent Child(ren) means any child from live birth who is under age 26 who is:

- your own natural offspring;
- your spouse's child;
- your lawfully adopted child as of the earliest of (i) the date the child is placed in your home or in a medical facility, (ii) the date a petition is filed for you to adopt the child, or (iii) the date an adoption agreement signed by you includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction; or
- any other child residing with you through legal mandate that is dependent on you for financial support.

Coverage for your child may be continued past age 26 if your child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance. You must submit proof of the child's incapacity and dependency to us within 31 days of the child's 26th birthday. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year after the two-year period following the termination date. We will continue to charge any appropriate premium for that child as long as they meet the definition of a dependent child. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If this is one-parent family or two-parent family coverage and all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which they did not qualify.

Your dependent children may not be insured as both a child and a named insured.

Your dependent children may not be insured by more than one named insured.

Complications of Pregnancy means that part of your pregnancy during which abnormal conditions or concurrent disease significantly affect the pregnancy's usual medical management. A complication may exist during the pregnancy, during the delivery, or after the delivery.

Coverage Effective Date means the date coverage begins as shown in the Certificate Schedule. The coverage effective date of this certificate is not the date you signed the application for coverage.

Covered Condition means any sickness, diagnosis, or loss shown on the Certificate Schedule which:

- occurs on or after the coverage effective date;
- occurs while coverage is in force; and
- is not excluded by name or specific description in this certificate.

Covered Person means any person covered under this certificate as described on the Certificate Schedule.

Date of Diagnosis means the date a physician confirms or a test proves that a covered condition exists. Date of diagnosis requirements vary by covered conditions.

Doctor or Physician means a person who:

- is licensed by the state to practice a healing art; and
- performs services for a covered person which are allowed by the physician's license.

For purposes of this definition, doctor or physician does not include any covered person or anyone related to any covered person by blood or marriage, a business or professional partner of any covered person or any person who has a financial affiliation or a business interest with any covered person.

Evidence of Insurability means a statement of your medical history which we will use to determine if you are approved for coverage.

Policy Anniversary Date means the date that occurs annually on the same day and in the same month as the First Policy Anniversary shown on the Policy Rate Schedule.

[

Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the coverage effective date shown on the Certificate Schedule.

]

Spouse means the person who is your partner through lawful marriage or your legally separated spouse.

Wherever the term **spouse** appears in the certificate, this provision also includes the definition of civil union and registered domestic partner.

Temporary Layoff or Leave of Absence means the named insured is temporarily absent from active employment for a period of time that has been agreed to in advance in writing by the employer. Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

[SECTION [5] – DEFINITIONS FOR CRITICAL ILLNESS BENEFIT

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

Benign Brain Tumor means a non-cancerous brain tumor resulting in neurological deficits including but not limited to loss of sight, loss of hearing, or balance disruption.

For purposes of this certificate, the following do not meet the definition of benign brain tumor:
- tumors of the skull;
- pituitary adenomas; and
- germinomas.

Benign Brain Tumor Date of Diagnosis is the date of the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Cardiologist means a doctor who is licensed to practice medicine and who is also licensed to practice by the American Board of Internal Medicine in the subspecialty of cardiovascular disease.

Coma means a continuous state of profound unconsciousness requiring intubation for respiratory assistance as the result of a severe traumatic brain injury lasting for a period of 7 or more consecutive days, characterized by the absence of:
- eye opening;
- verbal response; and
- motor response.

For purposes of this certificate, the following do not meet the definition of coma:
- coma due to stroke; and
- any medically induced coma.

Coma Date of Diagnosis is the date a doctor confirms a coma.

Coronary Artery Disease means a narrowing or blockage of one or more coronary arteries resulting from plaque buildup.

Coronary Artery Disease Date of Diagnosis is the date a cardiologist recommends a covered person undergo a surgical procedure of either a coronary artery bypass graft or valve replacement within 60 days following the date of recommendation.

Covered Accident means an unintended or unforeseen bodily injury sustained by a covered person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition and which:

- occurs on or after the coverage effective date;
- occurs while coverage is in force; and
- is not excluded by name or specific description in this certificate.

Covered Sickness means an illness, infection, disease, or any other abnormal physical condition that is not the result of an injury, which:

- occurs on or after the coverage effective date;
- occurs while coverage is in force; and
- is not excluded by name or specific description in this certificate.

Complications of pregnancy or childbirth will be treated as any other covered sickness.

Critical Illness means one of the covered conditions listed in the Benefit for Critical Illness section of the Certificate Schedule.

End Stage Renal (Kidney) Failure means chronic irreversible failure of the function of both kidneys such that the covered person must undergo at least weekly hemodialysis or peritoneal dialysis.

End Stage Renal (Kidney) Failure Date of Diagnosis means the date that a physician recommends regular hemodialysis or peritoneal dialysis to sustain life; the covered person has a kidney transplant performed; or the covered person is placed on the UNOS (United Network for Organ Sharing) list for a kidney transplant.

Heart Attack (Myocardial Infarction) means the ischemic death of a portion of heart muscle (myocardium) as a result of obstruction of one or more of the coronary arteries. A positive diagnosis of myocardial infarction must occur and must be supported by three or more of the following:

- chest pain;
- electrocardiographic (EKG) changes indicative of myocardial infarction; in the case of myocardial infarction associated with percutaneous coronary intervention (balloon angioplasty, stent implantation, and related procedures to increase the flow of blood through the coronary arteries), evolving ST elevations or new Q wave changes must
- be documented and included as one of the criteria in establishing a diagnosis;
  elevation of biochemical markers of myocardial necrosis; and
  confirmatory imaging studies.

In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying heart attack (myocardial infarction) as the cause of death will be accepted.

The following are not to be construed as a heart attack (myocardial infarction) for purposes of this certificate:

- an established (old) heart attack;
- angina;
- atherosclerotic heart disease;
- cardiac arrest (including arrhythmias);
- congestive heart failure;
- coronary artery disease; and
- any other disease, injury, or dysfunction of the cardiovascular system.

Heart Attack (Myocardial Infarction) Date of Diagnosis is the date the ischemic death of a portion of the heart muscle (myocardium) occurred based on the criteria listed under the heart attack (myocardial infarction) definition.

Injury means any damage or harm to the body that is the direct result of a covered accident and not related to any other cause.

Loss of Hearing means total and irrecoverable loss of hearing in both ears that follows a period where the covered person had the ability to hear.

The following are not to be construed as loss of hearing for purposes of this certificate:

- congenital birth defects;

- developmental delays; and
- any loss of hearing that can be corrected by any procedure, aid or device.

Loss of Hearing Date of Diagnosis means the date a physician confirms loss of hearing in both ears.

Loss of Sight means permanent reduction in sight certified by a physician that follows a period where the covered person was not legally blind such that:
- sight in the better eye reduced to a best corrected visual acuity of 20/200 or less (Snellen or E-Chart Acuity); or
- visual field remaining is less than 20° in the better eye.

The following are not to be construed as loss of sight for purposes of this certificate:
- congenital birth defects;
- developmental delays; and
- any loss of sight that can be corrected by any procedure, aid or device.

Loss of Sight Date of Diagnosis is the date a physician confirms the irreversible reduction of sight.

Loss of Speech means total and irrecoverable loss of speech that follows a period where the covered person had the ability to speak.

The following are not to be construed as loss of speech for purposes of this certificate:
- congenital birth defects;
- developmental delays; and
- any loss of speech that can be corrected by any procedure, aid or device.

Loss of Speech Date of Diagnosis is the date a physician confirms loss of speech.

Major Organ Failure Requiring Transplant means failure of the heart, kidney, liver, both lungs, or pancreas resulting in the covered person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

Major Organ Failure Requiring Transplant Date of Diagnosis is the date that the covered person is placed on the UNOS list for transplantation.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D means diagnosis of Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C or D resulting from exposure to HIV-contaminated or Hepatitis B, C or D contaminated fluids as the result of a covered accident during the normal course of performing an occupation for which remuneration is earned.
We will pay this benefit if:
- within five days of the covered accident, it is reported and recorded by the appropriate person according to the legislation, regulations, standards or guidelines that apply to the covered person's occupation or profession;
- the covered accident is investigated and a written investigation report is provided to us by the covered person's employer;
- a confirmatory antibody HIV or Hepatitis B, C or D test is taken within five days of the covered accident and HIV or Hepatitis B, C or D is not present;
- all HIV or Hepatitis B, C or D tests are performed by a state certified and licensed laboratory; and
- a follow-up confirmatory antibody HIV or Hepatitis B, C or D test is taken between 90 days and 180 days after the covered accident, and the result is positive.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D excludes:
- HIV or Hepatitis B, C or D infection as the result of IV drug use;
- HIV or Hepatitis B, C or D infection as the result of sexual transmission; and
- HIV or Hepatitis B, C or D infection determined not to have been the result of a covered accident.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D Date of Diagnosis is the date of a positive antibody test for HIV or Hepatitis B, C or D subsequent to a prior negative test for the same condition with a lapse of between 90 and 180 days between the two tests.

Permanent Paralysis Due to a Covered Accident means the complete and permanent loss of the use of two or more limbs due to a new paralysis as the result of a covered accident as defined in this certificate.

For purposes of this certificate losing the use of two or more limbs as the result of a stroke will not be construed as permanent paralysis due to a covered accident.

Permanent Paralysis Due to a Covered Accident Date of Diagnosis The date a physician diagnoses the paralysis or severed spinal cord.

Stroke means the sudden death of brain cells due to lack of oxygen, caused by blockage of blood flow or rupture of an artery to the brain.

The following are not to be construed as a stroke for purposes of this certificate:
- transient ischemic attack;
- brain injury related to trauma or infection;
- brain injury associated with hypoxia/anoxia or hypotension;
- vascular disease affecting the eye or optic nerve; and
- ischemic disorders of the vestibular system.

If a stroke results in death, an autopsy confirmation verifying stroke as the cause of death will be accepted.

Stroke Date of Diagnosis is the date a stroke occurs, and the diagnosis must be supported by:
- evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the stroke including but not limited to impaired motor function, altered sensation, vision loss, difficulty swallowing, or cognitive impairment; and
- confirmatory neuroimaging studies consistent with the diagnosis of a new stroke.

Sudden Cardiac Arrest means the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension. Sudden Cardiac Arrest does not mean a Heart Attack (Myocardial Infarction).

Sudden Cardiac Arrest Date of Diagnosis is the date the pumping action of the heart fails based on the sudden cardiac arrest definition.]

[SECTION [6] – DEFINITIONS FOR ADDITIONAL CRITICAL ILLNESS BENEFIT FOR DEPENDENT CHILDREN

Cerebral Palsy means a group of non-progressive disorders of movement and posture attributed to abnormal development of, or damage to motor control centers of the brain while a child's brain is still developing before, during, and immediately after birth. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception, and behavior, as well as seizures and secondary musculoskeletal problems.

Cerebral Palsy Date of Diagnosis is the date a physician makes or confirms an initial diagnosis of cerebral palsy after live birth.

Cleft Lip means a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose, including unilateral clefting and bilateral clefting.

Cleft Lip Date of Diagnosis is the date a physician makes or confirms an initial diagnosis of a cleft lip after live birth.

Cleft Palate means an opening between the roof of the mouth and the nasal cavity.

Cleft Palate Date of Diagnosis is the date a physician makes or confirms an initial diagnosis of a cleft palate after live birth.

Cystic Fibrosis means a hereditary disorder affecting the exocrine glands. It causes the production of abnormally thick mucus, leading to the blockage of the pancreatic ducts, intestines, and bronchi and often resulting in respiratory infection.

Cystic Fibrosis Date of Diagnosis is the date the condition is first diagnosed by a physician and supported by a sweat test with sweat chloride concentrations greater than 60 mmol/L.

Down Syndrome means a congenital disorder arising from a chromosome defect involving chromosome 21, causing intellectual impairment, physical abnormalities and developmental delays.

Down Syndrome includes:
- Trisomy 21- an individual has three instead of two chromosome 21's.
- Translocation - an extra part of chromosome 21 is attached to another chromosome.
- Mosaicism - the individual has an extra chromosome 21 in only some of the cells but not all of them. The other cells have the usual pair of chromosome 21's.

Down Syndrome Date of Diagnosis is the date a physician makes or confirms an initial diagnosis of Down syndrome through the study of the 21st chromosome after live birth.

Spina Bifida means a congenital defect of the spine in which part of the spinal cord and its meninges are exposed through a gap in the backbone. Spina bifida includes meningocele or myelomeningocele.

For purposes of this certificate, spina bifida occulta does not meet the definition for spina bifida.

Spina Bifida Date of Diagnosis means the date a physician makes or confirms an initial diagnosis of spina bifida, meningocele or myelomeningocele after live birth.]

[SECTION [7] – DEFINITIONS FOR CANCER BENEFITS

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

Complete Remission means having no symptoms and no signs that can be identified to indicate the presence of invasive or non-invasive cancer.

Hospital means a place that:
- is an institution licensed as a hospital and operating pursuant to law on a full-time basis;
- provides overnight care of injured and sick people;
- is supervised by a doctor;
- has full-time nurses supervised by a registered nurse; and
- has at its locations or uses on a pre-arranged basis: X-ray equipment, a laboratory and an operating room where surgical operations take place.

Notwithstanding the above, a hospital is not:
- a nursing home;
- an extended care facility;
- a skilled nursing facility;
- a rest home or home for the aged;
- a standalone rehabilitation center;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

Initial Benefit Amount refers to the amount a covered person receives for the initial diagnosis of cancer as shown on the Certificate Schedule.

Invasive Cancer (Including all Breast Cancer) means a disease that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.

Any cancer of the breast is considered invasive cancer including breast cancer which is classified as stage 0 or in situ.

The following are not to be construed as invasive cancer for purposes of this certificate:
- pre-malignant conditions or conditions with malignant potential;
- cancer that has not become invasive, typically classified as stage 0 or in situ;
- cancer on the surface of the body (skin) that may be: melanomas that are in situ or stage 1, which require only local treatment and affect only the melanoma and area close to it;
- basal cell carcinoma; or

- squamous cell carcinoma of the skin.

Invasive Cancer (Including all Breast Cancer) Date of Diagnosis means the date the tissue specimen, blood samples or titer(s) are taken upon which the diagnosis of invasive or non-invasive cancer is based.

Maintenance Drug Therapy means a course of systemic medication given to a patient after a cancer goes into complete remission because of primary treatment. Maintenance drug therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance drug therapy is meant to decrease the risk of cancer recurrence; it is not meant to treat a cancer that is still present.

Non-Invasive Cancer means a malignant tumor which is typically classified as stage 0 or in situ, that has not yet become invasive but is confined to the site of origin without having invaded neighboring tissue.

For purposes of this certificate, the following do not meet the definition of non-invasive cancer:
- pre-malignant conditions or conditions with malignant potential;
- any stage 0 or in situ cancer of the breast; and
- cancer on the surface of the body (skin) that may be:
- melanomas that are in situ or stage 1, which require only local treatment and affect only the melanoma and area close to it;
- basal cell carcinoma; or
- squamous cell carcinoma of the skin.

Non-Invasive Cancer Date of Diagnosis means the date the tissue specimen, blood samples or titer(s) are taken upon which the diagnosis of invasive or non-invasive cancer is based.

Pathologist means a doctor who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Skin Cancer means cancer on the surface of the body (skin) that may be:
- melanomas that are in situ or stage 1, which require only local treatment and affect only the melanoma and area close to it;
- basal cell carcinoma; or
- squamous cell carcinoma of the skin.

Skin Cancer Date of Diagnosis means the date the tissue specimen is taken on which the diagnosis of skin cancer is based.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a physician or other medical professional. The physician must observe these signs while acting within the scope of their license.

Treatment-Free from Cancer refers to the period of time without the consultation, care, or services provided by a physician. This includes receiving diagnostic measures and taking prescribed drugs and medicines including maintenance drug therapy.]

SECTION [8]– ELIGIBILITY AND EFFECTIVE DATE

Coverage Effective Date
Your coverage under the policy will start at 12:01 a.m. Standard Time in the time zone where you live on the coverage effective date shown on your Certificate Schedule for purposes of all dates under this certificate of coverage.

Enrollment
An individual who is a member of an eligible class may enroll in coverage during the eligibility period, as shown on the Policy Rate Schedule, that follows the later of:
- the policy effective date as shown on the Policy Rate Schedule;
- the date the individual first becomes a member of an eligible class;
- the date the individual completes the policyholder probationary period shown on the application of the policyholder, if applicable; or
- the date the individual meets evidence of insurability requirements, if any.

A **late entrant** is an individual who fails to enroll during the initial product offering, the new hire eligibility period or has voluntarily cancelled previous coverage and is reapplying. A late entrant may only apply during an open enrollment period with evidence of insurability. The policyholder and the company will determine when an open enrollment period begins and ends.

After the coverage effective date, the named insured cannot make any changes to the coverage type under this certificate until an open enrollment period, unless the named insured has a qualifying event. A **qualifying event,** for the purposes of this provision, means:

- birth or adoption of a child;
- issuance of a court order requiring coverage of a child;
- marriage;
- divorce; or
- death of a covered person.

The named insured will have 31 days from the date of occurrence of a qualifying event in which to:

- notify us they wish to make a change;
- complete any required enrollment form; and
- pay any additional premium, if applicable.

Delayed Coverage Effective Date
The effective date of your coverage will be delayed if you are not a member of an eligible class on the coverage effective date shown on the Certificate Schedule. The coverage will be effective on the date that you return to status as a member of an eligible class. If this is named insured and spouse coverage, one-parent family or two-parent family coverage, coverage on the spouse and/or dependent children will be effective on the date that you return to status as a member of an eligible class.

Who is Covered by This Certificate
If this is named insured coverage as shown on the Certificate Schedule, we insure you, the named insured.

If this is named insured and spouse coverage as shown on the Certificate Schedule, we insure you and your spouse.

If this is one-parent family coverage as shown on the Certificate Schedule, we insure you and your dependent children.

If this is two-parent family coverage as shown on the Certificate Schedule, we insure you, your spouse and your dependent children.

You may not apply for coverage for your spouse if your spouse is covered as a named insured under other coverage.

Coverage on newborn children begins from the moment of live birth. Coverage for adopted children begins with the date of placement into your custody for adoption. If the coverage is named insured coverage or named insured and spouse coverage, the coverage on the newborn or newly adopted child will end 31 days later if you do not request a change in coverage type as provided in the Enrollment provision.

[SECTION [9] – BENEFIT FOR CRITICAL ILLNESS

Critical Illness Benefit
We will pay this benefit if a covered person is diagnosed with a critical illness, as defined in this certificate, and:

- the date of diagnosis is while this certificate is in force;
- [the critical illness is diagnosed during the 12 months following the coverage effective date and is not a pre-existing condition;] and
- the critical illness is not excluded by name or specific description in this certificate.

[We will not pay the Critical Illness Benefit for any critical illness diagnosed during the 12 months following the coverage effective date if the critical illness is a pre-existing condition.]

We will pay the percentage of the covered person's face amount shown on the Certificate Schedule for the critical illness diagnosed.

We will not pay the benefit for Benign Brain Tumor if any covered person is diagnosed prior to the coverage effective date with any of the following conditions:

- neurofibromatosis I;
- neurofibromatosis II;
- von Hippel-Lindau;
- tuberous sclerosis;
- Li-Fraumani syndrome;
- cowden disease; and
- turcot syndrome.

We will not pay the benefit for Sudden Cardiac Arrest if the sudden cardiac arrest is caused by or contributed to by a Heart Attack (Myocardial Infarction).

If a covered person is on the UNOS list for a combined transplant (example: heart and lung) as listed in the definition of major organ failure requiring transplant, a single benefit will be paid.

We will pay the benefit for Coronary Artery Disease, Loss of Hearing, Loss of Sight, Loss of Speech or Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D only once per covered person per lifetime.

If the date of diagnosis of two or more critical illness covered conditions is on the same day, we will pay only one critical illness benefit. We will pay the larger of the two critical illness benefits.

The Critical Illness Benefit is not payable for conditions other than the critical illness covered conditions defined in this certificate.

Benefit Payable Upon Subsequent Diagnosis of a Critical Illness

If a covered person has been diagnosed with and received a benefit for a critical illness and is subsequently diagnosed with a *different* critical illness, we will pay the percentage of the covered person's face amount shown on the Certificate Schedule for the critical illness diagnosed, if:

- the date of diagnosis of the subsequent critical illness is more than 180 days after any previous date of diagnosis for a critical illness;
- the subsequent date of diagnosis is while coverage under this certificate is in force; and
- the critical illness is not excluded by name or specific description in this certificate.

If a covered person has been diagnosed with and received a benefit for a critical illness and is subsequently diagnosed with the *same* critical illness (other than Coronary Artery Disease and Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D), we will pay an amount equal to 25% of the face amount shown for the covered person as shown on the Certificate Schedule, if:

- the date of diagnosis of the subsequent critical illness is more than 180 days after any previous date of diagnosis for the same critical illness;
- the covered person has not received treatment during the 180 days between the dates of diagnosis for the same critical illness. For purposes of the preceding sentence, treatment does not include medications and follow-up visits to the covered person's physician;
- the subsequent date of diagnosis is while coverage under this certificate is in force; and
- the critical illness is not excluded by name or specific description in this certificate.]

[SECTION [10] – ADDITIONAL CRITICAL ILLNESS BENEFIT FOR DEPENDENT CHILDREN

Additional Critical Illness Benefit for Dependent Children

We will pay this benefit if a covered dependent child is initially diagnosed with a critical illness, as defined in this certificate, and:

- [the additional critical illness for dependent children is diagnosed during the 12 months following the coverage effective date and is not a pre-existing condition;]
- the date of diagnosis is while this certificate is in force; and
- the critical illness is not excluded by name or specific description in this certificate.

[We will not pay the Additional Critical Illness Benefit for Dependent Children for any critical illness diagnosed during the 12 months following the coverage effective date if the critical illness is a pre-existing condition.]

We will pay up to the maximum benefit amount shown on the Certificate Schedule per covered dependent child.

The Additional Critical Illness Benefit for Dependent Children is not payable for conditions other than the critical illness covered conditions defined in this certificate.

A Benefit Payable Upon Subsequent Diagnosis of a Critical Illness does not apply to the diagnosis of an Additional Critical Illness Benefit for Dependent Children.]

[SECTION [11] – CANCER BENEFITS

Invasive Cancer (Including all Breast Cancer) Benefit
We will pay this benefit when you are diagnosed as having invasive cancer if:
- the date of diagnosis is while this certificate is in force;
- [the invasive cancer is diagnosed during the 12 months following the coverage effective date and is not a pre-existing condition;] and
- the invasive cancer is not excluded by name or specific description in this certificate.

We will pay the percentage of the covered person's face amount shown on the Certificate Schedule for the diagnosed cancer.

[We will not pay the Invasive Cancer (Including all Breast Cancer) Benefit for any invasive cancer diagnosed during the 12 months following the coverage effective date if the invasive cancer is a pre-existing condition.]

Invasive Cancer (Including all Breast Cancer) must be diagnosed in one of two ways:

1. Pathological Diagnosis
A *pathological diagnosis* of invasive cancer made by a pathologist is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of malignancy diagnosis must be in accordance with the standards established by the American Board of Pathology. A pathological diagnosis of invasive cancer can be made before or after death.

2. Clinical Diagnosis
A *clinical diagnosis* of invasive cancer is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:
- a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a doctor is treating the covered person for invasive cancer.

In addition to the pathological or clinical diagnosis required, we may require additional information from the doctor and hospital.

If a covered person has been diagnosed with and received a benefit for non-invasive cancer and is subsequently diagnosed with invasive cancer, we will pay the Invasive Cancer (Including all Breast Cancer) Benefit for the covered person as shown on the Certificate Schedule, up to the Maximum Benefit Amount for the Invasive Cancer (Including all Breast Cancer) Benefit and subject to the provisions of this certificate, if the date of diagnosis of the invasive cancer is more than 180 days after the date of diagnosis for the non-invasive cancer.

If the diagnosis of two or more invasive or non-invasive cancers is on the same day, we will pay only one cancer benefit. We will pay the larger of the two cancer benefits.

Non-Invasive Cancer Benefit
We will pay this benefit when you are diagnosed as having non-invasive cancer, if:
- the date of diagnosis is while this certificate is in force;
- [the non-invasive cancer is diagnosed during the 12 months following the coverage effective date and is not a pre-existing condition;] and
- the non-invasive cancer is not excluded by name or specific description in this certificate.

We will pay the percentage of the covered person's face amount shown on the Certificate Schedule for the diagnosed non-invasive cancer.

[We will not pay the Non-Invasive Cancer Benefit for any non-invasive cancer diagnosed during the 12 months following the coverage effective date if the non-invasive cancer is a pre-existing condition.]

Non-Invasive Cancer must be diagnosed in one of two ways:

1. Pathological Diagnosis
A *pathological diagnosis* of non-invasive cancer made by a pathologist is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of malignancy diagnosis must be in accordance with the standards established by the American Board of Pathology. A pathological diagnosis of non-invasive cancer can be made before or after death.

2. Clinical Diagnosis
A *clinical diagnosis* of non-invasive cancer is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:
- a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a doctor is treating the covered person for non-invasive cancer.

In addition to the pathological or clinical diagnosis required, we may require additional information from the doctor and hospital.

If a covered person has been diagnosed with and received a benefit for invasive cancer and is subsequently diagnosed with non-invasive cancer, we will pay the Non-Invasive Cancer Benefit for the covered person as shown on the Certificate Schedule, up to the Maximum Benefit Amount for the Non-Invasive Cancer Benefit and subject to the provisions of this certificate, if the date of diagnosis of the non-invasive cancer is more than 180 days after the date of diagnosis for the invasive cancer.

If the diagnosis of two or more invasive or non-invasive cancers is on the same day, we will pay only one cancer benefit. We will pay the larger of the two cancer benefits.

Benefit Payable Upon Reoccurrence of Invasive Cancer (Including all Breast Cancer)
If a covered person has been diagnosed with and received a benefit for Invasive Cancer (Including all Breast Cancer) and is diagnosed with a reoccurrence of invasive cancer, we will pay an amount equal to 25 percent of the initial benefit amount for the invasive cancer diagnosed if:
- [the invasive cancer is not caused or contributed to by a critical illness for which benefits have been paid;]
- the covered person is treatment-free from invasive cancer for at least 12 months before the date of reoccurrence diagnosis;
- the covered person is in complete remission prior to the date of a reoccurrence diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of invasive cancer;
- the date of diagnosis is while coverage under this certificate is in force; and
- the invasive cancer is not excluded by name or specific description in this certificate.

The Benefit Payable Upon Reoccurrence of Invasive Cancer (Including all Breast Cancer) is not payable for non-invasive or skin cancer.

Skin Cancer Initial Diagnosis Benefit
We will pay the amount shown on the Certificate Schedule if any covered person is diagnosed with skin cancer if:
- the date of diagnosis is while this certificate is in force;
- [the skin cancer is diagnosed during the 12 months following the coverage effective date and is not a pre-existing condition;] and
- the skin cancer is not excluded by name or specific description in this certificate.

We will accept a clinical diagnosis if a pathological diagnosis cannot be made.

This benefit is limited to one payment per covered person per lifetime.]

[SECTION [12] – WELLBEING ASSISTANCE BENEFIT

We will pay the amount shown on the Certificate Schedule to help with monetary expenditures such as transportation, missed work, and other incidentals, as a result of having one of the routine, preventative tests covered by this certificate. The test must be performed after the waiting period while this certificate is in force. **Waiting Period** means the first 30 days following each covered person's coverage effective date during which benefits are not payable.

The covered tests include:

- Blood test for triglycerides
- Bone marrow testing
- BRCA1 or BRCA2 testing
- Breast ultrasound
- Carotid Doppler
- CA 15-3
- CA 125
- CEA
- Chest x-ray
- Colonoscopy
- Electrocardiogram (EKG, ECG)
- Echocardiogram (ECHO)
- Fasting blood glucose
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA
- Serum protein electrophoresis
- Serum cholesterol test for HDL and LDL
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

We will pay a maximum of one day per covered person per calendar year.]

[SECTION [13] –EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS

We will not pay benefits for a critical illness that occurs as a result of a covered person's:

Felonies or Illegal Occupations
Committing or attempting to commit a felony or engaging in an illegal occupation.

Intoxicants and Narcotics
Being intoxicated or under the influence of any narcotic or voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the covered person's physician.

Suicide
Committing or trying to commit suicide or injuring oneself intentionally, whether sane or not.

War or Armed Conflict
Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.

[Pre-Existing Condition Limitation
We will not pay the Critical Illness Benefit, Benefits Payable Upon Subsequent Diagnosis of a Critical Illness [or Additional Critical Illness Benefit for Dependent Children] for any covered person when the critical illness is a pre-existing condition as

defined in this certificate, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a critical illness.] [Credit toward the satisfaction of the pre-existing condition limitation period will be given for any continuous time the covered person was covered under the pre-existing condition clause of previous coverage through another carrier if:

- The previous coverage was similar to or exceeded the coverage provided under this certificate;
- The covered person was insured under the previous coverage at the time of enrollment in the coverage provided by this certificate; and
- The covered person was insured under the coverage provided by this certificate on the policy effective date shown on the Policy Rate Schedule.

The covered person is responsible for furnishing proof of previous coverage, to include type of coverage, length the previous coverage was in force and the date the previous coverage terminated.]

[SECTION [14] –EXCLUSIONS AND LIMITATIONS FOR CANCER

We will not pay the Invasive Cancer (Including all Breast Cancer) Benefit, Non-Invasive Cancer Benefit, Benefit Payable Upon Reoccurrence of Invasive Cancer (Including all Breast Cancer) or Skin Cancer Initial Diagnosis Benefit for a covered person's invasive cancer or non-invasive cancer that:

[Pre-Existing Condition Limitation

Is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is initially diagnosed as having invasive or non-invasive cancer**.** No Pre-existing Condition Limitation will be applied for dependent children who are born or adopted while you are covered under this policy, and who are continuously covered from the date of birth or adoption.] [Credit toward the satisfaction of the pre-existing condition limitation period will be given for any continuous time the covered person was covered under the pre-existing condition clause of previous coverage through another carrier if:

- The previous coverage was similar to or exceeded the coverage provided under this certificate;
- The covered person was insured under the previous coverage at the time of enrollment in the coverage provided by this certificate; and
- The covered person was insured under the coverage provided by this certificate on the policy effective date shown on the Policy Rate Schedule.

The covered person is responsible for furnishing proof of previous coverage, to include type of coverage, length the previous coverage was in force and the date the previous coverage terminated.]

Geographical Limitation

Is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

SECTION [15] – TERMINATION OF INSURANCE

Termination of The Named Insured's Coverage

The coverage on a named insured under the policy will terminate on the earliest of the following dates:

- the date the policy terminates;
- your policyholder cancels the policy and does not offer replacement coverage;
- the end of the grace period following the premium due date and we do not receive the required premium for the named insured;
- the date the named insured is no longer in an eligible class;
- the date the named insured's class is no longer included for insurance; or
- the date the next premium is due after the named insured asks us to end coverage.

We will provide coverage for a claim for which we are liable under the terms of this certificate if the loss occurs while you are covered.

When Coverage Ends on Your Spouse and Dependent Children

If this is a named insured and spouse coverage or two-parent family coverage, coverage on your spouse will end on the earliest of the following dates:

- the date your coverage under the policy terminates;
- the end of the grace period following the premium due date and we do not receive the required premium for your spouse;

- the date the next premium is due after you ask us to end your spouse's coverage;
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled. If this is a named insured and spouse coverage or two-parent family coverage and you divorce your spouse, or your marriage is annulled and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which they did not qualify.

If this is a one-parent family or two-parent family coverage, coverage on your dependent children will end on the earliest of the following dates:
- the date your coverage under the policy terminates;
- the end of the grace period following the premium due date and we do not receive the required premium for your dependent children;
- the date the next premium is due after you ask us to end your dependent children's coverage;
- the date you die; or
- the date they no longer meet the definition of dependent children shown in the General Definitions section of this certificate.

We will provide coverage for a claim for which we are liable under the terms of this certificate if the loss occurs while your spouse and/or dependent child is covered.

Leave of Absence Under the Family and Medical Leave Act
A named insured may continue coverage during absences for family or medical leave. If a named insured is on a family or medical leave of absence, coverage will continue under this certificate as if the named insured were in active employment, if the following conditions are met:
- the premiums are paid in accordance with the policy's provisions; and
- the policyholder has approved the named insured's leave in writing.

Coverage will be continued for up to the greater of:
- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, upon the named insured's return to active employment [:
- no new pre-existing condition limitation will be applied; and
-]no new evidence of insurability will be required to reinstate the coverage which was in effect before the leave began.

In order for these conditions to apply, the policyholder must notify us and commence paying premiums for the named insured's coverage within 31 days following a named insured's return to active employment following a leave of absence for family or medical leave.

[The time period in the pre-existing condition limitation period will continue to run through a named insured's family or medical leave of absence.]

Leave of Absence – Other
If the named insured is on a temporary layoff or leave of absence other than for family or medical leave and premium is paid in accordance with the policy's provisions, you will be covered through the premium due date immediately following the date the temporary layoff or leave of absence begins.

If premium is remitted beyond the premium due date referenced above, our only liability will be to return the premium.

SECTION [16] – GENERAL PROVISIONS

Coverage Provided by the Policy
We insure a covered person for loss according to the provisions of the policy.

Misstatement of Age
If the age of the named insured has been misstated, we will make any equitable adjustment of premiums. We will refund any excess premium payment over the amount due based on your correct age. We will request payment for any overdue premium based on your correct age. If the misstatement is discovered after a payment is due and payable, we will reduce

or increase the benefit amount payable by the amount of excess or overdue premium due to the misstatement. If a named insured is not eligible because of age we will refund all premiums paid.

Misstatement of Tobacco Status
If there is a misstatement in the application of the named insured's tobacco status, we will adjust the benefits payable to the amounts which would have been purchased at the correct tobacco status in consideration of the most recent premium. We will not make such an adjustment after this policy has been in force for two years from the coverage effective date.

Contestability
No statement made by any named insured relating to any covered person's insurability shall be used to contest the validity of the insurance after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made and unless the statement is contained in a written instrument signed by the named insured making the statement, unless the statement was fraudulent.

Contest means that we question the validity of coverage under this policy through a letter to the policyholder or the named insured. This contest is effective on the date we mail the letter and refund premiums.

All statements made by the policyholder or any named insured shall be deemed representations and not warranties. No written statement made by the policyholder or any named insured shall be used in any contest unless a copy of the statement is furnished to the policyholder or the named insured.

Policyholder as Agent
For purposes of the policy and this certificate, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed our agent.

SECTION [17] – CLAIM PROVISIONS

Notice of Claim
If a covered person has an injury or sickness that may result in a claim for benefits under the policy, written notice must be given to us at our home office. This must be done within 90 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as is reasonably possible. The notice must contain enough information to identify the covered person.

If a loss occurs before receiving notification of our decision on any coverage amount subject to evidence of insurability requirements, the coverage amount applicable to the claim will be the coverage amount previously approved and on file with us and your policyholder.

Claim Forms
When we receive written or verbal notice of a claim, claim forms will be sent with which to file Proof of Loss. If these forms are not given to you within 15 days, you will be excused from filing the forms as long as you send us Proof of Loss as described below.

Proof of Loss
We must receive a written proof of loss within 90 days after the covered loss begins. If you are not able to give us written proof of loss within 90 days, it will not have a bearing on this claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time stated unless you are legally unable to do so.

Written proof of loss must include one or more of the following:
- documentation of diagnosis or treatment provided by a physician or medical facility and supported by clinical, radiological, histological, pathological, or laboratory evidence;
- a physician's bill, a hospital bill or other proof of charges; and
- in the case of death, a certified copy of the death certificate, or other lawful evidence providing equivalent information.

Authorization for Release of Information
We may request written authorization from a covered person. This authorization may be required in order for us to obtain the necessary medical and non-medical information needed for proof of loss and continuing proof of loss. Failure to provide us with written authorization may result in the delay of processing your claim. If the covered person does not send proof to us and we are not able to obtain proof of loss that is required, we will be unable to make a claim decision.

Time of Payment of Claim
After we receive written proof of loss and process your claim, we will pay any benefits due immediately upon receipt of due written proof of such loss.

Payment of Claim
Benefits will be paid directly to you unless we receive your valid written authorization to pay benefits elsewhere, such as to a hospital or a physician's office. This is called assignment of benefits. We reserve the right to determine if an assignment of benefits is valid and consistent with applicable laws.

You have the right to name a beneficiary. It is important to list the full name of each beneficiary and that all beneficiary designations are kept current and provided to us or the policyholder. If you wish to change the beneficiary designation, you may do so by sending us or the policyholder a completed, dated, and signed beneficiary designation change form. Changes in beneficiary designations will take effect on the date notice of the beneficiary designation is signed by the named insured.

If one is not named, and we still owe you benefits at your death, benefits due will be paid in this order to your:
- spouse;
- children;
- parents;
- brothers and sisters; or
- estate.

If benefits are payable to your estate, we can pay benefits up to $1,000 to someone related to you by blood or marriage who we feel is fairly entitled to them. If we do this, we will have no responsibility for this payment because we made it in good faith.

Unpaid Premium
When a claim is paid under the policy, any premium then due and unpaid for your certificate may be deducted by us from the claim payment.

Overpaid Claim
We have the right to recover any overpayments due to:
- fraud; or
- any error made during the processing of a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum. This may include reducing or withholding future payments.

We will not recover more money than the amount we overpaid.

Questions Concerning the Named Insured's Claim
If you have questions concerning your claim, you can call us at our home office. We are open Monday through Friday from 8:30 a.m. until 5:00 p.m. Eastern Time.

Physical Exam and Autopsy
We can require that any covered person be examined or tested by one or more physicians, other medical practitioners, or vocational experts of our choice as often as it is reasonably necessary while this claim is pending. We can also require an autopsy in the event of the death of any covered person in those states where this is allowed. Either or both of these will be done at our expense.

Legal Action
We cannot be sued for benefits under the policy:
- until 60 days after we are sent written proof of loss; or
- more than three years after the time has passed in which we require written proof of loss.

Claim Review
If a claim is denied, we will give written notice of:
- the reason for denial;
- the policy provision that relates to the denial;
- the right to ask for a review of the claims; and

- the right to submit any additional information that might allow us to change our decision.

You may, upon written request, read any reports that are not confidential. For a small fee, we will make copies of those reports.

Appeals Procedure
Prior to filing any lawsuit and within 60 days after denial of a claim, you or your estate must appeal any denial of benefits under the policy by making a written request for review of the denial.

If you are dissatisfied with the resolution reached through our internal grievance system regarding medical necessity, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases:
District of Columbia Department of Health Care Finance Office of the Health Care Ombudsman and Bill of Rights

One Judiciary Square
441 4th St. N.W., Suite 900 South
Washington, D.C. 20001
1.877.685.6391, 202.724.7491
Fax: 202.442.6724

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non-Medical Necessity cases:
Commissioner

Department of Insurance, Securities and Banking
1050 First Street, NE
Suite 801
Washington, DC 20002
202.727.8000
Fax: 202.354.1085.

If the resolution reached through the insurer's internal grievance system results in the denial of a claim, you or your authorized representative may request arbitration for review of the denial. Arbitration is pursuant to D.C. Law and the arbitrators can award consequential or punitive damages. You may waive any rights to a trial in court, including the right to a jury trial.

Workers' Compensation Not Affected
The policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

[SECTION [18] – PORTABILITY

Portability allows you to continue coverage when coverage under the policyholder's group policy would otherwise end due to an eligible portability event.

Portability is made a part of this certificate and is subject to all of the provisions, limitations and exclusions of this certificate.

Any future changes made in the policyholder's group policy will not apply to coverage a covered person has ported, unless required by law.

Eligible Portability Events
We will provide specified disease insurance portability coverage, subject to these provisions.
Such coverage will not be available for a named insured, unless:

- the named insured's specified disease insurance terminates under the provision Termination of the Named Insured's Coverage for one of the following reasons:
  - the named insured is no longer in an eligible class; or
  - the named insured's class is no longer included for insurance;

- we receive a written request by the named insured and payment of all premiums due for the portability coverage not later than 63 days after such termination;
- such termination is while the policy is in force; and
- the request is made on a form we furnish or approve for that purpose.

However, you will not be considered eligible to port coverage at the time of an eligible portability event if:
- the policyholder's policy is closed to new enrollments;
- the policyholder's policy is cancelled by us;
- the policyholder cancels the policy and offers replacement coverage; or
- the policyholder's policy is changed to exclude the class of covered persons to which you belong.

Coverage
The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy for specified disease insurance when the named insured's insurance terminated. We will allow you to decrease the face amount at the time portability is requested; provided that the face amount cannot be decreased below a Face Amount for Named Insured of $5,000. Portability coverage may include any eligible family members who were covered under the policy. Any change made to the policy after a named insured is insured under the portability privilege will not apply to that named insured unless it is required by law.

Once premiums and all forms have been received, portability coverage will be effective on the day after coverage under the policy terminates.

Premiums
You must make all premium contributions for ported coverage. Premiums are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The premium rates are based on the portability rates in effect on the date you apply to port coverage. We have the right to change the portability premium we charge on any premium due date. Written notice will be given at least [45] days before the change is to take effect.

Grace Period (If Premiums Are Not Paid When Due)
After the first premium, if the premium is not paid when it is due, it can be paid during the next 31 days. These 31 days are called the grace period. During the grace period this coverage will stay in force. If the premium is not paid before the grace period ends, the coverage provided by this certificate will terminate at the end of the grace period.

Termination of Insurance
Insurance under this portability privilege will automatically end on the earliest of the following dates:
- the date the named insured again becomes eligible for specified disease insurance under the policy;
- the last day for which premiums have been paid, if the named insured fails to pay premiums when due, subject to the Grace Period provision;
- the date the named insured dies; or
- the date insurance under this Portability provision is cancelled by us for any reason upon 31 days notice.

With respect to insurance for your spouse and dependent children, insurance under this portability privilege will automatically end on the earliest of the following dates:
- the date the named insured's insurance terminates;
- as to your dependent children, the date the dependent child ceases to qualify as a dependent child as defined in this certificate; or
- as to your spouse, the date the next premium is due after you divorce your spouse or your marriage is annulled or the date of your spouse's death.

In the event your policyholder's policy is terminated, any covered person who has continued their coverage under the Portability provision prior to the policyholder's policy termination date will not be affected.

Once insurance under this portability provision is cancelled, it cannot be reinstated.

Termination of the Policy
Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits, terms and conditions for portability coverage will be determined as if the policy had remained in force and effect.]

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

CANCER BENEFITS RIDER

RIDER SCHEDULE

Policyholder	[ABC Employer]	Group Policy Number:	[201141890 E111111]
Named Insured:	[John Doe]	Certificate Number:	[000000000]
Coverage Type:	[Two-Parent Family]	Rider Coverage Effective Date:	[01-01-2022]

BENEFITS FOR CANCER

Air Ambulance — $2,000 per trip
Maximum of two trips per confinement per covered person

Ambulance — $250 per trip
Maximum of two trips per confinement per covered person

Anesthesia
- General Anesthesia — 25% of Surgical Procedures Benefit
- Local Anesthesia — [$25] [$30] [$50] per procedure

Anti-Nausea Medication — [$25] [$40] [$50] per day administered or per prescription filled
Maximum Benefit Amount of [$100] [$160] [$200] per covered person per calendar month

Blood/Plasma/Platelets/Immunoglobulins — [$150] [$175] [$250] per day
Maximum Benefit Amount of $10,000 per covered person per calendar year

Bone Marrow Donor Screening — $50 per lifetime
Maximum of one per covered person per lifetime

Bone Marrow or Peripheral Stem Cell Donation — [$500] [$750] [$1,000] per lifetime
Maximum of one per covered person per lifetime

Bone Marrow or Peripheral Stem Cell Transplant — [$3,500] [$4,000] [$7,000] per transplant
Maximum of two transplant benefits per covered person per lifetime

Cancer Vaccine — $50 per lifetime
Maximum of one per covered person per lifetime

Companion Transportation — $.50 per mile
Maximum Benefit Amount of [$1,000] per covered person per round trip

Egg(s) Extraction or Harvesting/Sperm Collection and Storage (Cryopreservation)
- Egg(s) Extraction or Harvesting or Sperm Collection — [$500] [$700] [$1,000] maximum of one per covered person per lifetime
- Egg(s) or Sperm Storage — [$150] [$175] [$300] maximum of one per covered person per lifetime

Experimental Treatment — [$200] [$250] [$300] per day
Maximum Benefit Amount of [$2,000] [$2,500] [$3,000] per covered person per calendar year

Hair/External Breast/Voice Box Prosthesis [$200] [$200] [$350] per covered person per calendar year

Home Health Care Services [$50] [$75] [$100] per day
Maximum of 30 days per covered person per calendar year or twice the number of days of hospital confinement per covered person per calendar year

Hospice
Initial hospice care $1,000 maximum of one per lifetime
Daily hospice care $50 per day
Maximum Benefit Amount of $15,000 for initial and daily hospice care per covered person per lifetime

Hospital Confinement
30 days or less [$100] [$200] [$300] per covered person per day
31 days or more [$200] [$400] [$600] per covered person per day

Lodging [$50] [$50] [$75] per day
Maximum of 90 days per covered person per calendar year

Medical Imaging Studies [$50] [$75] [$125] per study
Maximum Benefit Amount of [$100] [$150] [$250] per covered person per calendar year

Outpatient Surgical Center [$150] [$250] [$500] per day
Maximum Benefit Amount of [$450] [$750] [$1,500] per covered person per calendar year

Private Full-time Nursing Services [$50] [$100] [$150] per covered person per day

Prosthetic Device/Artificial Limb [$1,000] [$1,500] [$3,000] per device or limb
Maximum Benefit Amount of [$2,000] [$3,000] [$6,000] per covered person per lifetime

Radiation/Chemotherapy or Immunotherapy
Self-Administered [$100] [$200] [$400] maximum of one per covered person per calendar month

Self-Injected
Topical
Oral Non-Hormonal
Maximum Benefit Amount of [$1,200] [$2,400] [$4,800] per covered person per calendar year

Physician-Administered [$250] [$350] [$700] maximum of one per covered person per calendar month

Injected chemotherapy by medical personnel
Pump
Immunotherapy
Maximum Benefit Amount of [$3,000] [$4,200] [$8,400] per covered person per calendar year

Hormonal Therapy [$50] [$75] [$150] maximum of one per covered person per calendar month

Oral Hormonal
Maximum Benefit Amount of [$600] [$900] [$1,800] per covered person per calendar year

Reconstructive Surgery [$30] [$40] [$60] per surgical unit
Maximum Benefit Amount of [$1,500] [$2,000] [3,000] per covered person per procedure, including 25% for general anesthesia

Second Medical Opinion [$150] [$200] [$300] per lifetime
Maximum of one per covered person per lifetime

Skilled Nursing Care Facility [$75] [$100] [$150] per covered person per day up to the number of days for hospital confinement

Supportive or Protective Care Drugs and Colony Stimulating Factors [$25] [$40] [$50] per day
Maximum Benefit Amount of [$200] [$320] [$400] per covered person per calendar year

Surgical Procedures [$30] [$50] [$60] per surgical unit
Maximum Benefit Amount of [$1,800] [$3,500] [$4,800] per covered person per procedure

Transportation $.50 per mile
Maximum Benefit Amount of [$1,000] [$1,200] [$1,500] per covered person per round trip

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
[1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com]
A Stock Company

CANCER BENEFITS RIDER
THIS IS A LIMITED RIDER - READ IT CAREFULLY.

THIS RIDER IS NOT ATTACHED TO A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

All terms, definitions of terms, conditions, exclusions and limitations stated in the certificate for cancer will also apply to this rider unless we state otherwise in this rider.

Coverage Provided by This Rider
We will provide the benefit stated in this rider as a part of the certificate to which it is attached for the person(s) shown on the Rider Schedule, subject to any limitations in this rider or the certificate.

Definitions
Bone Marrow or Peripheral Stem Cell Donation means receiving bone marrow or peripheral stem cells from a matched donor, other than yourself, for a transplant procedure.

Bone Marrow or Peripheral Stem Cell Transplant means harvesting, storage, reinfusion or subsequent reinfusion of bone marrow or peripheral stem cells taken from a matched donor or yourself, performed under general anesthesia or intravenous (IV) sedation.

Calendar Month means any of the twelve parts into which the calendar year is divided.

Calendar Year means the period beginning on the rider coverage effective date shown on the Rider Schedule and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Chemotherapy means treatment with chemical substances that have a cancericidal effect for the purpose of the destruction of malignant cells during the treatment of invasive cancer.

Commercial Transportation means a vehicle licensed to carry passengers for a fee (*i.e.*, plane, train or bus).

Confined or Confinement means the assignment to a bed as a resident inpatient in a hospital on the advice of a doctor or, for the purposes of the hospital confinement benefit only, confinement in an observation unit within a hospital for a period of no less than 20 continuous hours on the advice of a doctor.

Disabled means you are:
- unable to perform the material and substantial duties of your job;
- not, in fact, working at any job for pay or benefits; and
- under the regular and appropriate care of a doctor for the treatment of invasive cancer.

Experimental Treatment means:
- drugs or chemical substances that are pending approval by the United States Food and Drug Administration (FDA) for use in the treatment of invasive cancer; and
- surgery or therapy endorsed by either the National Cancer Institute or the American Cancer Society for experimental studies.

Family Member means your spouse, civil union partner, sister or brother (includes step-sister and step-brother), children (includes step-children), parents (includes step-parents), grandchildren, father or mother-in-law, brothers or sisters-in-law and spouses, as applicable, to any of these.

Home Health Agency means an agency that is certified by your state government. Its main purpose is to arrange and provide nursing services, home health aide services, and other related services.

Hospice means an organization that provides care for the terminally ill that:
- is licensed by a governmental agency;
- is accredited by the Joint Commission on Accreditation of Hospitals; or
- is qualified to receive benefit payments from Medicare or Medicaid.

The organization must have on its staff at least one doctor and one registered nurse and must keep complete medical records for each patient.

Hospice does not include:
- food services, meals, and dietary counseling; or
- services related to well-baby care; or
- services provided by volunteers; or
- support for the family after the death of the covered person.

Hospital means a place that:
- is an institution licensed as a hospital and operating pursuant to law on a full-time basis;
- provides overnight care of injured and sick people;
- is supervised by a doctor;
- has full-time nurses supervised by a registered nurse; and
- has at its locations or uses on a pre-arranged basis: x-ray equipment, a laboratory and an operating room where surgical operations take place.

Notwithstanding the above, a hospital is not:
- a nursing home;
- an extended care facility;
- a skilled nursing facility;
- a rest home or home for the aged;
- a standalone rehabilitation center;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

Immunotherapy means treatments intended to improve the immune system by providing antibodies, colony stimulating factors, or immunoglobulins for the purpose of treating invasive cancer.

Injected Chemotherapy means medications taken intravenously, including but not limited to continuous infusion that has a cancericidal effect for the purpose of the destruction of malignant cells during the treatment of invasive cancer.

Invasive Cancer (Including all Breast Cancer) means a disease that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.

Any cancer of the breast is considered invasive cancer including breast cancer which is classified as stage 0 or in situ. The following are not to be construed as invasive cancer for purposes of this rider:
- pre-malignant conditions or conditions with malignant potential;
- cancer that has not become invasive, typically classified as stage 0 or in situ;
- cancer on the surface of the body (skin) that may be: melanomas that are in situ or stage 1 which require only local treatment and affect only the melanoma and area close to it;
- basal cell carcinoma; and
- squamous cell carcinoma of the skin.

Material and Substantial Duties of Your Job means duties that:
- are normally required to perform your regular job; and
- cannot be reasonably omitted or modified.

Performing your job at a particular worksite or in a particular building is not a material and substantial duty of your job, provided that your employer will allow you to perform your job at a different worksite or in a different building.

Observation Unit means a specified area within a hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a doctor and which:
- is under the direct supervision of a doctor or registered nurse;
- is staffed by nurses assigned specifically to that unit; and
- provides care seven days per week, 24 hours per day.

Oral Hormonal Chemotherapy means medications taken by mouth to prevent or control the spread or recurrence of malignant cells by:
- altering the production or level of hormones; or
- blocking hormones.

Oral Non-Hormonal Chemotherapy means medications taken by mouth, other than oral hormonal therapy medications, that have a cancericidal effect for the purpose of the destruction of malignant cells during the treatment of invasive cancer.

Outpatient Surgical Center means a place that:
- is equipped for outpatient surgical procedures administered by qualified physicians;
- provides anesthesia (other than local) by a licensed anesthesiologist or Certified Registered Nurse Anesthetist; and
- has written agreements with local hospitals to accept patients immediately who develop complications.

Private Full-time Nursing means providing services only to a covered person for at least eight consecutive hours during any 24-hour period while confined to a hospital.

Radiation means the following treatments for the purpose of the destruction of malignant cells during the treatment of invasive cancer:
- tele radiotherapy, using either natural or artificially propagated radiation; or
- interstitial or intracavitary application of radium or radioisotopes in sealed or non-sealed sources.

Office visits, laboratory tests, diagnostic x-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy, laser surgery or other procedures related to these treatments will not be considered radiation.

Reconstructive Surgery means surgery for the purpose of reconstruction of anatomic defects that result from treatment of invasive cancer.

Skilled Nursing Care Facility means a place where a covered person goes to recover from an illness and:
- is licensed and operated as a skilled nursing care facility according to the law of the jurisdiction in which it is located;
- is a legally operated facility that can be a wing or part of a hospital;
- operates 24 hours a day and will accept inpatients on an overnight basis;
- is supervised by a doctor;
- has a 24-hour nursing staff which is supervised by a registered nurse (RN); and
- keeps written daily records for each patient.

Notwithstanding the above, a skilled nursing care facility is not:
- a rest home or a home for the aged;
- a place that provides mostly custodial care; or
- a place for alcoholics or drug addicts.

Skin Cancer means cancer on the surface of the body (skin) that may be:
- melanomas that are in situ or stage 1, which require only local treatment and affect only the melanoma and area close to it;
- basal cell carcinoma; or
- squamous cell carcinoma of the skin.

Supportive or Protective Care Drugs and Colony Stimulating Factors means**:**
- bone marrow growth factors;
- radiation and chemotherapy protectants; and
- medications that promote bone growth.

Supportive or Protective Care Drugs must be approved for the treatment of invasive cancer by the United States Food and Drug Administration and must be prescribed by a physician.

Surgery means the cutting into the skin or other organ to accomplish any of the following goals:
- take a biopsy of a suspicious lump that results in a diagnosis of invasive cancer;
- remove diseased tissues or organs;
- remove an obstruction;
- reposition structures to their normal position;
- redirect channels;
- transplant tissue or whole organs;
- implant mechanical or electronic devices;
- reconstruct anatomic defects that result from treatment of invasive cancer; or
- restore proper function.

The following will not be considered a surgical procedure for the purposes of this rider:
- venipuncture (drawing blood);
- lumbar puncture;
- epidural steroid injections;
- removal of skin tags;
- catherization; or
- scopes not requiring biopsy or removal of tissue.

Topical Chemotherapy means a chemotherapy drug placed directly onto the skin that has a cancericidal effect for the purpose of the destruction of malignant cells during the treatment of invasive cancer.

Under the Regular and Appropriate Care of a Doctor means you are being cared for on a regular basis by a doctor and the care you are receiving is appropriate for the treatment of invasive cancer which disable(s) you, unless you have reached your maximum point of recovery and the doctor states that continued treatment would be of no benefit to you.

U. S. Government Hospital means a hospital that is funded by the U. S. Government primarily for military enlisted personnel and their families and military veterans.

Eligibility For Benefits
We will pay cancer benefits if any covered person incurs a charge and receives treatment by a physician for the benefits shown on the Rider Schedule for invasive cancer, including skin cancer where applicable, if:
- the treatment is recommended by a physician;
- the covered person receives treatment for invasive cancer or skin cancer while this rider is in force; and
- the invasive cancer or treatment is not excluded by name or specific description in this rider.

If invasive cancer is not pathologically or clinically diagnosed until after you die, we will only pay benefits for invasive cancer treatment performed during the 45-day period before your death.

Invasive Cancer (Including all Breast Cancer) must be diagnosed in one of two ways:

1. Pathological Diagnosis
A *pathological diagnosis* of invasive cancer made by a pathologist is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of malignancy diagnosis must be in accordance with the standards established by the American Board of Pathology. A pathological diagnosis of invasive cancer can be made before or after death.

2. Clinical Diagnosis
A *clinical diagnosis* of invasive cancer is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:
- a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a doctor is treating the covered person for invasive cancer.

In addition to the required pathological or clinical diagnosis, we may require additional information from the attending doctor and hospital.

We will only pay benefits for skin cancer where specifically stated.

If treatment for invasive cancer or skin cancer is received in a U. S. Government Hospital, we will not require a covered person to incur charges for services for benefits to be payable.

Cancer Benefits

Air Ambulance
We will pay the amount shown on the Rider Schedule for Air Ambulance if a charge is incurred and a licensed professional air ambulance company transports by air any covered person to or from a hospital or between medical facilities while the covered person is confined as an inpatient for the treatment of invasive cancer. We will pay for no more than two trips each time the covered person is confined as an inpatient for the treatment of invasive cancer.

There is no limit to the total number of trips for which a covered person receives benefits, other than two trips each time the covered person is confined as an inpatient for the treatment of invasive cancer. Benefits for ambulance transportation, other than air ambulance, will be paid under the Ambulance benefit.

Ambulance
We will pay the amount shown on the Rider Schedule for Ambulance if a charge is incurred and a licensed medical professional ambulance company transports any covered person by ground transportation to or from a hospital or between medical facilities, while the covered person is confined as an inpatient for the treatment of invasive cancer. We will pay for no more than two trips each time a covered person is confined as an inpatient for the treatment of invasive cancer.

There is no limit to the total number of trips for which a covered person can receive benefits, other than two trips each time a covered person is confined as an inpatient for the treatment of invasive cancer. Benefits for air ambulance will be paid under the Air Ambulance benefit.

Anesthesia
We will pay the amount shown on the Rider Schedule if any covered person incurs a charge and receives general anesthesia administered by an anesthesiologist or a Certified Registered Nurse Anesthetist during a surgical procedure that is performed for the treatment of invasive cancer and for which a benefit is payable.

If a covered person incurs a charge and receives local anesthesia during a surgical procedure performed for the treatment of invasive cancer for which a benefit is payable, we will pay the amount shown on the Rider Schedule.

If a covered person has more than one surgical procedure performed at the same time, we will pay only one Anesthesia benefit. We will pay the Anesthesia benefit for the surgical procedure performed that has the highest dollar value. Any anesthesia administered for reconstructive surgery will be paid only under the Reconstructive Surgery benefit provision.

This benefit is payable for skin cancer.

There is no limit to the number of times a covered person can receive benefits for anesthesia during the treatment of invasive or skin cancer.

Anti-Nausea Medication
We will pay the amount shown on the Rider Schedule if a covered person incurs a charge for medication for nausea as a result of radiation or chemotherapy treatments prescribed by a doctor during the treatment of invasive cancer.

This benefit is payable each day a covered person receives anti-nausea medication administered in a physician’s office, clinic, hospital or prescriptions filled for anti-nausea medication, subject to the Maximum Benefit Amount shown on the Rider Schedule.

We will only pay one Anti-Nausea Medication benefit per day regardless of the number of anti-nausea medications a covered person receives on the same day.

If a covered person receives a prescription for anti-nausea that is for more than one month, this benefit is limited to the calendar month in which the charge is incurred. Refills of the same prescription within the same calendar month are not considered a different anti-nausea medicine.

Benefits for radiation and/or chemotherapy prescribed by your physician are only available under the Radiation/Chemotherapy or Immunotherapy benefit. Benefits for supportive or protective care drugs and colony stimulating factors are only available under the Supportive or Protective Care Drugs and Colony Stimulating Factors benefit.

Blood/Plasma/Platelets/Immunoglobulins
We will pay the amount shown on the Rider Schedule if any covered person incurs a charge and receives a transfusion of blood/plasma/platelets/immunoglobulins during the treatment of invasive cancer, subject to the Maximum Benefit Amount.

Bone Marrow Donor Screening
We will pay the amount shown on the Rider Schedule if any covered person provides documentation of participation in a screening test as a potential bone marrow donor.
This benefit is limited to one payment per covered person per lifetime.

Bone Marrow or Peripheral Stem Cell Donation
We will pay the amount shown on the Rider Schedule if any covered person incurs a charge for receiving bone marrow or stem cells in connection with a covered transplant procedure during the treatment of invasive cancer.

This benefit is limited to one payment per covered person per lifetime.

Bone Marrow or Peripheral Stem Cell Transplant
We will pay the amount shown on the Rider Schedule if any covered person incurs a charge for and receives a bone marrow or peripheral stem cell transplant for the treatment of invasive cancer.

This benefit is limited to two transplant payments per covered person per lifetime.

Cancer Vaccine
We will pay the amount shown on the Rider Schedule if any covered person incurs a charge and receives any invasive cancer vaccine that is United States Food and Drug Administration (FDA) approved for the prevention of invasive cancer and while this rider is in force. The vaccine must be administered by licensed medical personnel while this rider is in force.
This benefit is limited to one payment per covered person per lifetime.

Companion Transportation
We will pay the amount shown on the Rider Schedule if a charge is incurred for one companion to accompany a covered person to another city where the covered person is receiving treatment for invasive cancer if:

- the doctor advises treatment or diagnosis of your invasive cancer in another city;
- charges are incurred for commercial travel (*i.e.,* plane, train or bus);
- the destination is more than 50 miles one way from the city where the covered person lives; and
- treatment is for invasive cancer.

We will measure the mileage for the most direct route from the residential address where the covered person lives to the city in which treatment is received.

This benefit is not payable for personal vehicle transportation.

Benefits for air ambulance and ambulance are only available under the Air Ambulance and Ambulance benefits.

There is no limit to the number of times a covered person receives benefits for Companion Transportation, subject to the Maximum Benefit Amount shown on the Rider Schedule per covered person per round trip.

Egg(s) Extraction or Harvesting/Sperm Collection and Storage (Cryopreservation)
We will pay the amount shown on the Rider Schedule if a covered person incurs a charge to have eggs extracted and harvested or sperm collected.

We will pay an additional benefit as shown on the Rider Schedule for the storage of a covered person's eggs or sperm when a charge is incurred to store it with a licensed reproductive tissue bank or a similar licensed storage facility.

The extraction, harvesting, collection and storage must occur prior to the chemotherapy, radiation or immunotherapy treatment that has been prescribed by a doctor for the covered person's treatment of invasive cancer.

We will pay these benefits only once per covered person per lifetime.

Experimental Treatment
We will pay the amount shown on the Rider Schedule each day any covered person incurs a charge and receives hospital, medical or surgical care in connection with experimental treatment of invasive cancer. These treatments must be prescribed by a physician and must be received in an experimental invasive cancer treatment program.

Payment of this benefit is in place of payment of any other benefit for the same covered treatments.

There is no limit to the number of treatments a covered person can receive, subject to the Maximum Benefit Amount shown on the Rider Schedule.

Hair/External Breast/Voice Box Prosthesis
We will pay the amount shown on the Rider Schedule if any covered person incurs a charge and receives a hair prosthesis, external breast prosthesis or voice box prosthesis needed as a direct result of invasive cancer.

There is no limit to the number of years a covered person can receive benefits for a hair prosthesis, external breast prosthesis or voice prosthesis.

Home Health Care Services
We will pay the amount shown on the Rider Schedule each day any covered person incurs a charge and receives any of the following home health care services prescribed by a doctor for the treatment of invasive cancer instead of confinement in a hospital:
- professional nursing provided by a registered nurse;
- home health aide services provided under the supervision of a registered nurse or qualified therapist;
- physical therapy;
- occupational therapy;
- speech therapy and audiology;
- respiratory and inhalation therapy;
- nutrition counseling by a nutritionist or dietitian;
- medical social services;
- medical supplies;
- prosthesis and orthopedic appliances;
- rental or purchase of durable medical equipment; or
- administration of drugs or medicine.

Prior confinement in a hospital is not required. The service must be rendered by a home health agency as part of a plan of care established by the doctor and the home health agency.

We will pay this benefit for up to the greater of:
- 30 days per calendar year; or
- twice the number of days the covered person was confined to a hospital during a calendar year for the treatment of invasive cancer.

We will not pay the Home Health Care Services benefit for:
- services or supplies for personal comfort or convenience, including housekeeping services;
- services performed by family members or provided by the hospital;
- child care; or
- food services or meals other than dietary counseling.

This benefit will not be paid for days that the Hospice benefit is payable.

There is no limit to the number of years a covered person can receive benefits for Home Health Care Services subject to the calendar year maximum.

Hospice
We will pay the amount shown on the Rider Schedule each day any covered person incurs a charge and receives hospice care, as the result of invasive cancer, consisting of one or more of the following services received by a covered person for whom a doctor determines that invasive cancer treatments are no longer of benefit and that the covered person is expected to live for only six months or less:

- a visit from a representative of a hospice care team at home;
- the services of a hospital on an outpatient basis under the direction of a hospice;
- a visit to a hospice on an outpatient basis for treatment or services; and
- confinement to a hospice care facility.

We will pay the amount shown on the Rider Schedule for initial hospice care on the first day a covered person receives hospice care. Initial hospice care is payable once per covered person per lifetime regardless of the number of times a covered person receives hospice care.

We will not pay this benefit while a covered person is confined to a hospital, or to a skilled nursing care facility. This benefit will not be paid for days that the Home Health Care Services benefit is payable.

There is no limit to the number of days a covered person can receive benefits for hospice, subject to the Maximum Benefit Amount shown on the Rider Schedule.

Hospital Confinement
We will pay the amount shown on the Rider Schedule each day any covered person incurs a charge for confinement to a hospital (including intensive care) for the treatment of invasive cancer.

If we pay benefits for a period of hospital confinement and a covered person is confined to a hospital again within 30 days for the treatment of invasive cancer, we will treat this confinement as a continuation of the prior confinement.

If more than 30 days have passed between the periods of hospital confinement (including intensive care), we will treat this confinement as a new confinement.

There is no limit to the number of days any covered person can receive benefits for being confined to a hospital for the treatment of invasive cancer.

Lodging
We will pay the amount shown on the Rider Schedule each day any covered person or any one adult companion or family member incurs a charge for lodging required while the covered person is being treated for invasive cancer more than 50 miles from the covered person's residence.

We will pay up to 90 days per calendar year.

Medical Imaging Studies
We will pay the amount shown on the Rider Schedule if any covered person incurs a charge for a covered medical imaging study. It must be prescribed by a doctor for the treatment of invasive cancer and after the initial diagnosis or follow-up evaluation of invasive cancer.
Covered imaging studies are:

- Computed Tomography (CT) imaging or Computed Axial Tomography (CAT Scan);
- Magnetic Resonance (MR) or Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET or Bone Scan); and
- Ultrasound (US) Imaging.

There is no limit to the number of times a covered person can receive this benefit, subject to the calendar year maximum shown on the Rider Schedule.

Outpatient Surgical Center
We will pay the amount shown on the Rider Schedule each day any covered person incurs a charge and has surgery at an outpatient surgical center for the treatment of invasive cancer. This does not include surgery received in the emergency room or while confined to the hospital.

We will only pay benefits for one outpatient surgery per day, even if a covered person has more than one surgical procedure performed.

This benefit is not payable on the same day as the Hospital Confinement benefit.

Benefits for the surgical procedure and anesthesia are payable under the surgery benefits and the Anesthesia benefit.

There is no limit to the number of days a covered person can receive this benefit, subject to the calendar year maximum shown on the Rider Schedule.

Private Full-time Nursing Services
We will pay the amount shown on the Rider Schedule each day any covered person incurs a charge for private full-time nursing services (other than those regularly furnished by the hospital) required and authorized by a doctor while confined to a hospital for the treatment of invasive cancer.

Private full-time nursing must be performed by a registered nurse (RN), a licensed practical or a licensed vocational nurse.

Nursing services performed by family members or provided by the hospital are not covered.

There is no limit to the number of days a covered person can receive benefits for the use of services of a private full-time nurse.

Prosthetic Device/Artificial Limb
We will pay the amount shown on the Rider Schedule if any covered person incurs a charge and receives a surgically implanted prosthetic device or artificial limb which is prescribed by a doctor needed as a direct result of invasive cancer surgery.

We will pay any appropriate surgery or reconstructive surgery benefit as described in those benefit provision(s) for the surgical procedure required for the implant.

This benefit does not include coverage for tissue expanders or a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap.

We will pay for no more than one of the same type of prosthetic device or artificial limb per site.

Radiation/Chemotherapy or Immunotherapy
We will pay the amount shown on the Rider Schedule if any covered person incurs a charge and receives one or more of the covered treatments listed below during the treatment of invasive cancer.

Covered Treatments consist of the following:

- **Chemotherapy,** consisting of one or more of the following:
    - chemotherapy treatments injected by medical personnel in a doctor's office, clinic or hospital;
    - chemotherapy treatments injected by yourself or anyone other than personnel in a doctor's office, clinic or hospital;
    - a pump for chemotherapy initially filled or refilled;
    - a prescription for topical chemotherapy;
    - a prescription for oral hormonal chemotherapy; or
    - a prescription for oral non-hormonal chemotherapy.

- **Radiation**, consisting of radioactive treatments delivered by medical personnel in a doctor's office, clinic, or hospital.

- **Immunotherapy**, consisting of treatments intended to improve the immune system by providing antibodies, colony stimulating factors, or immunoglobulins for the purpose of treating invasive cancer.

Covered Treatments injected or delivered by medical personnel in a doctor's office, clinic or hospital are payable each calendar month, subject to the calendar year amount shown on the Rider Schedule and are limited to the calendar month in which the covered person incurs a charge for the treatment of invasive cancer.

Covered Treatments delivered by any other method, as listed above, are payable each calendar month, subject to the calendar year amount shown on the Rider Schedule and are limited to the calendar month in which the covered person incurs a charge for the treatment of invasive cancer.

Payment of this benefit is not based on the number, duration or frequency of the covered treatment.

If a covered person receives a prescription for chemotherapy that is for more than one month, this benefit is limited to the calendar month in which the charge is incurred. Refills of the same prescription within the same calendar month are not considered a different chemotherapy medicine.

Radiation and chemotherapy treatments must be approved for the treatment of invasive cancer by the United States Food and Drug Administration (FDA).

Radioactive treatments delivered by medical personnel are not payable each month a radium implant or radioisotope remains in the body.

This benefit is not payable for the same day that the Experimental Treatment benefit is paid.

Benefits for supportive or protective care drugs and colony stimulating factors prescribed by your doctor are only available under the Supportive or Protective Drugs and Colony Stimulating Factors benefit. Benefits for anti-nausea medication prescribed by your doctor are only available under the Anti-nausea Medication benefit.

We will not pay this benefit for office visits, laboratory tests, diagnostic x-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy or other procedures related to these treatments.

Reconstructive Surgery
We will pay the amount shown on the Rider Schedule if any covered person incurs a charge for a reconstructive surgery that:

- requires an incision;
- is performed by a doctor for treatment of invasive cancer; and
- is due to invasive cancer.

We will pay for no more than two surgeries per site.

We will use the most current published Physicians' Relative Value table and the Current Procedural Terminology (CPT) Code, provided by the doctor who performed your surgery, to determine the surgical unit value assigned to each surgery.

How to calculate this benefit:

Dollar amount per unit X Surgical Unit Value = Surgery Benefit Amount (up to the maximum per procedure)

If the Reconstructive Surgery benefit calculated above is less than the Maximum Benefit Amount allowed for this benefit, then we will also pay up to 25% of the reconstructive surgery benefit amount if a covered person incurs charges for and has general anesthesia administered during surgery.

In no event, will the amount paid for this benefit exceed the lesser of:

- the surgical unit value multiplied by the dollar amount per unit shown above plus 25% for general anesthesia administered during reconstructive surgery; or
- the maximum amount per procedure shown above.

If a covered person has more than one reconstructive surgery performed at the same time and through the same incision, we will pay only one Reconstructive Surgery benefit. We will pay the benefit that has the highest dollar value.

If a covered person has more than one reconstructive surgery performed at the same time but through different incisions, we will pay for each one.

Second Medical Opinion
We will pay the amount shown on the Rider Schedule if any covered person incurs a charge and obtains a second medical opinion from another doctor on recommended surgery or treatment following the positive diagnosis of invasive

cancer. A covered person is not required to obtain a second medical opinion in order to receive the surgical or other benefits under this rider.

This benefit is limited to one payment per covered person per lifetime.

Skilled Nursing Care Facility
We will pay the amount shown on the Rider Schedule each day any covered person incurs a charge and is confined to a skilled nursing care facility during the treatment of invasive cancer.

Confinement must begin within 14 days after a covered person is released from a hospital. We will pay this benefit for no more than the number of days we paid the Hospital Confinement benefit for your most recent confinement.

There is no limit to the number of times a covered person can receive benefits for being confined to a skilled nursing care facility during the treatment of any invasive cancer as long as each confinement begins within 14 days after a covered person is released from a hospital.

Supportive or Protective Care Drugs and Colony Stimulating Factors
We will pay the amount shown on the Rider Schedule each day any covered person incurs a charge and receives supportive or protective care drugs and/or colony stimulating factors for the treatment of invasive cancer.

Benefits for supportive or protective care drugs and/or colony stimulating factors will only be payable for the day a covered person has the prescription filled.

We will only pay one benefit per day regardless of the number of supportive or protective care drugs and/or colony stimulating factors a covered person receives on the same day.

If a covered person receives a prescription for supportive or protective care drugs and/or colony stimulating factors that is for more than one month, this benefit is limited to the calendar month in which the charge is incurred. Refills of the same prescription within the same calendar month are not considered a different supportive or protective care drug and/or colony stimulating factor medicine.

Benefits for radiation/chemotherapy or immunotherapy will only be available under the Radiation/Chemotherapy or Immunotherapy benefit. Benefits for anti-nausea medication prescribed by a doctor solely to prevent nausea will only be available under the Anti-Nausea Medication benefit. Medications prescribed for experimental treatment will only be available under the Experimental Treatment benefit.

There is no limit to the number of times a covered person can receive this benefit, subject to the calendar year maximum shown on the Rider Schedule.

Surgical Procedures
We will pay the amount shown on the Rider Schedule if any covered person incurs a charge for a surgical procedure performed by a doctor for the treatment of invasive cancer, subject to the Maximum Benefit Amount.

The Maximum Benefit Amount is the lesser of:
- the surgical unit value multiplied by the dollar amount per unit; or
- the maximum amount per procedure.

We will use the most current published Physicians' Relative Value table and the Current Procedural Terminology (CPT) Code, provided by the doctor who performed your surgery, to determine the surgical unit value assigned to each surgery.

How to calculate this benefit:

Dollar amount per unit X Surgical Unit Value = Benefit Amount (up to the maximum per procedure)

If a covered person has more than one surgical procedure performed at the same time and through the same incision, we will pay only one Surgical Procedures benefit. We will pay the benefit that has the highest dollar value. If a covered person has more than one surgical procedure performed at the same time but through different incisions, we will pay for each one.

Surgery performed laparoscopically with more than one incision will be considered one surgical procedure regardless of the number of incisions. We will pay the benefit that has the highest dollar value.

Benefits for reconstructive surgical procedures for invasive cancer will only be paid under the Reconstructive Surgery benefit.

This benefit is payable for skin cancer.

There is no limit to the number of times a covered person can receive benefits for surgical procedures for the treatment of invasive or skin cancer.

Transportation
We will pay the amount shown on the Rider Schedule if any covered person receiving treatment incurs a charge and must travel from their residence more than 50 miles one way from the city in which the covered person lives to receive a diagnosis or treatment for invasive cancer. Treatment for invasive cancer must be:

- prescribed by a doctor; and
- not available locally.

We will pay this benefit when charges are incurred for travel to and from your destination for either:

- commercial travel (*i.e.,* plane, train or bus); or
- non-commercial travel (*i.e.,* use of a personal car or ride-sharing services).

We will measure the mileage for the most direct route from the residential address where the covered person lives to the city in which treatment is received.

We will pay this benefit for each round trip, subject to the Maximum Benefit Amount shown on the Rider Schedule per covered person.

Benefits for air ambulance and ambulance are only available under the Air Ambulance and Ambulance benefits.

There is no limit to the number of times a covered person can receive benefits for transportation.

Waiver of Premium
You, the named insured, will not be required to continue to pay premiums to keep this rider in force if you have been disabled as the result of invasive cancer if:

- the treatment is recommended by a physician;
- you receive treatment for invasive cancer while this rider is in force; and
- you are disabled for more than 90 consecutive days while this rider is in force.

If you do not have a job, we will not require you to pay premiums as long as you are kept at home because of your invasive cancer and are under the regular and appropriate care of a doctor. At home means in your house or yard. However, you can follow your doctor's orders even if it means leaving home.

If you do have a job, we will require an employer’s statement of your inability to perform the material and substantial duties of your job.

We may also each month thereafter require a doctor’s statement that you continue to be disabled as defined in this rider.

After it has been determined that you have been disabled for more than 90 consecutive days, we will not require you to pay premiums for the length of time you continue to be disabled because of your invasive cancer.
We can require that you be examined by a doctor, chosen by us, to verify that you are disabled. This will be done at our expense.

Before we waive your premiums, you must send us a written notice prepared by your doctor stating:

- the date you were diagnosed as having invasive cancer;
- that you are disabled due to invasive cancer; and
- the date you became continuously disabled because of invasive cancer.

We will waive the premium beginning on the next premium due date for the certificate and any attached riders up to a lifetime maximum of 24 months from the first day you are disabled due to invasive cancer.

If we do not require you to pay premiums during a period of disability, and you become disabled again within 30 days because of invasive cancer, we will treat this disability as the same disability. If more than 30 days have passed between the periods of disability, we will treat this disability as a new disability and you must be disabled again for more than 90 consecutive days before we will waive your premiums.

You must send us written notice as soon as you are no longer disabled. We will assume you are no longer disabled if:
- you do not send us satisfactory proof of loss when we request it;
- you do not agree to have physical examination by a doctor chosen by us; or
- you notify us that you are no longer disabled.

You must pay all premiums to keep this rider in force beginning with the first premium due after you are no longer disabled.

This benefit does not apply to your spouse or to your children. We will waive premiums only if you, the named insured, are disabled due to invasive cancer. However, if this is a one-parent or a two-parent family rider, we will waive premiums on all family members insured by this rider.

EXCLUSIONS AND LIMITATIONS FOR CANCER

[Pre-existing Condition Limitation
We will not pay Cancer Benefits for treatment of invasive cancer, including skin cancer where applicable, that is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person receives treatment for invasive cancer, including skin cancer where applicable.]

Geographical Limitation
We will not pay Cancer Benefits for treatment of invasive cancer, including skin cancer where applicable, that is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

TERMINATION OF THE NAMED INSURED'S COVERAGE
The coverage on a named insured under this rider will terminate on the earliest of the following dates:
- the date coverage terminates under the certificate to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for the named insured;
- the date the named insured is no longer in an eligible class;
- the date the named insured's class is no longer included for insurance; or
- the date the next premium is due after the named insured asks us to end coverage.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while you are covered.

WHEN COVERAGE ENDS ON YOUR SPOUSE AND DEPENDENT CHILDREN
If this is a named insured and spouse coverage or two-parent family coverage, coverage on your spouse will end on the earliest of the following dates:
- the date the coverage terminates under the certificate to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for your spouse;
- the date the next premium is due after you ask us to end your spouse's coverage;
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled. If this is a named insured and spouse coverage or two-parent family coverage and you divorce your spouse, or your marriage is annulled and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which the covered person did not qualify.

If this is a one-parent family or two-parent family coverage, coverage on your dependent children will end on the earliest of the following dates:
- the date your coverage terminates under the certificate to which this rider is attached;

- the end of the grace period following the premium due date and we do not receive the required premium for your dependent children;
- the date the next premium is due after you ask us to end your dependent children's coverage;
- the date you die; or
- the date they no longer meet the definition of dependent children shown in the General Definitions section of the certificate.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while your spouse and/or dependent child is covered.

Coverage for your child may be continued past age 26 if your child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance. You must submit proof of the child's incapacity and dependency to us within 31 days of the child's 26th birthday. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year after the two-year period following the termination date. We will continue to charge any appropriate premium for that child as long as they meet the definition of a dependent child. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If this is one-parent family or two-parent family coverage and all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which they did not qualify.

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Secretary]

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

FIRST DIAGNOSIS BUILDING BENEFIT RIDER

RIDER SCHEDULE

Policyholder: [ABC Employer]

Group Policy Number: [201141890 E111111]

Named Insured: [John A. Doe]

Certificate Number: [0000000000]

Coverage Type: [Two-Parent Family]

Rider Coverage Effective Date: [02-01-2022]

Rider Year: [02/01- 01/31] of each year this rider is in effect

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FIRST DIAGNOSIS BUILDING BENEFIT RIDER

THIS IS A LIMITED RIDER - READ IT CAREFULLY.

THIS RIDER IS NOT ATTACHED TO A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

All terms, definitions of terms, conditions, exclusions and limitations stated in the certificate for [critical illness] [and] [cancer] will also apply to this rider unless we state otherwise in this rider.

Coverage Provided by This Rider
We provide the benefit stated in this rider as a part of the certificate to which it is attached for the person(s) shown on the Rider Schedule, subject to any limitations in the rider or the certificate.

First Diagnosis Building Benefit
Amount for Named Insured: $1,000 for each rider year this rider is in force after the rider effective date, up to a maximum of 10 rider years

[Amount for Spouse: $500 for each year coverage for the spouse under this rider is in force, up to a maximum of 10 years]

[Amount for Dependent Children: $500 for each year coverage for the dependent children under this rider is in force, up to a maximum of 10 years]

We will pay the First Diagnosis Building Benefit if a covered person is diagnosed with a [critical illness (other than Coronary Artery Disease)] [or] [Invasive Cancer (Including all Breast Cancer)], as defined in the certificate to which this rider is attached, and:

- the date of diagnosis is while this rider is in force;
- [for a date of diagnosis during the 12 months following the rider effective date, the [critical illness][or] [Invasive Cancer (Including all Breast Cancer)] is not a pre-existing condition;] and
- the [critical illness] [or] [Invasive Cancer (Including all Breast Cancer)] is not excluded by name or specific description in the certificate.

We will pay the First Diagnosis Building Benefit amount for the covered person, for each rider year this rider has been in force after the rider effective date and before the covered person's diagnosis is made, up to a maximum of 10 rider years [or, in case of spouse or dependent children, each year coverage for the spouse or dependent children under this rider is in force and before the covered person's diagnosis is made, up to a maximum of 10 years]. **Rider Year** means the period shown on the Rider Schedule. **Year** means 12 calendar months. In the event the covered person's diagnosis occurs before the end of the first rider year following the rider effective date, the First Diagnosis Building Benefit amount for that covered person will be $500 if the covered person is the named insured and $250 if the covered person is the named insured's covered spouse or dependent child, if applicable.

We will pay this benefit only once for each covered person insured by this rider.

[We will not pay this benefit for [skin cancer or non-invasive cancer, as defined in the certificate to which the rider is attached, or] any [critical illness] [or] [Invasive Cancer (Including all Breast Cancer)] diagnosed [during the 12 months following the rider effective date if the [critical illness] [or] [Invasive Cancer (Including all Breast Cancer)] is a pre-existing condition.]

[Invasive Cancer (Including all Breast Cancer) must be diagnosed in one of two ways:
1. Pathological Diagnosis
A *pathological diagnosis* of invasive cancer made by a pathologist is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of malignancy diagnosis must be in accordance with the standards

established by the American Board of Pathology. A pathological diagnosis of invasive cancer can be made before or after death.

2. Clinical Diagnosis

A *clinical diagnosis* of invasive cancer is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:

- a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a doctor is treating the covered person for invasive cancer.

In addition to the pathological or clinical diagnosis required, we may require additional information from the doctor and hospital.]

TERMINATION OF THE NAMED INSURED'S COVERAGE

The coverage on a named insured under this rider will terminate on the earliest of the following dates:

- the date coverage terminates under the certificate to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for the named insured;
- the date the named insured is no longer in an eligible class;
- the date the named insured's class is no longer included for insurance; or
- the date the next premium is due after the named insured asks us to end coverage.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while you are covered.

WHEN COVERAGE ENDS ON YOUR SPOUSE AND DEPENDENT CHILDREN

If this is a named insured and spouse coverage or two-parent family coverage, coverage on your spouse will end on the earliest of the following dates:

- the date the coverage under the certificate terminates to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for your spouse;
- the date the next premium is due after you ask us to end your spouse's coverage;
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled. If this is a named insured and spouse coverage or two-parent family coverage and you divorce your spouse, or your marriage is annulled and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which the covered person did not qualify.

If this is a one-parent family or two-parent family coverage, coverage on your dependent children will end on the earliest of the following dates:

- the date your coverage under the certificate terminates to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for your dependent children;
- the date the next premium is due after you ask us to end your dependent children's coverage;
- the date you die; or
- the date they no longer meet the definition of dependent children shown in the General Definitions section of the certificate.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while your spouse and/or dependent child is covered.

Coverage for your child may be continued past age 26 if your child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance. You must submit proof of the child's incapacity and dependency to us within 31 days of the child's 26th birthday. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year after the two-year period following the termination date. We will continue to charge any appropriate premium for that child as long as they meet the definition of a dependent child. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If this is one-parent family or two-parent family coverage and

all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which they did not qualify.

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Secretary]

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

HEART BENEFITS RIDER

RIDER SCHEDULE

Policyholder	[ABC Employer]	Group Policy Number:	[201141890 E111111]
Named Insured:	[John Doe]	Certificate Number:	[000000000]
Coverage Type:	[Two-Parent Family]	Rider Coverage Effective Date:	[01-01-2022]

HEART BENEFITS

COVERED HEART PROCEDURES:	**Percentage of Applicable Face Amount in the Certificate Schedule**
Abdominal Aortic Aneurysm Surgery	100%
Aortic Valve Replacement or Repair	100%
Mitral Valve Replacement or Repair	100%
Coronary Artery Bypass Graft Surgery	75%
Atherectomy	10%
Automatic Implantable (or internal) Cardioverter Defibrillator (AICD)	10%
Balloon Angioplasty	10%
Heart Catherization	10%
Laser Angioplasty	10%
Pacemaker Placement	10%
Stent Implantation	10%
Thrombectomy (clot removal) using catheters such as AngioJet	10%

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HEART BENEFITS RIDER

THIS IS A LIMITED RIDER - READ IT CAREFULLY.

THIS RIDER IS NOT ATTACHED TO A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

All terms, definitions of terms, conditions, exclusions and limitations for critical illness stated in the certificate will also apply to this rider unless we state otherwise in this rider.

Coverage Provided By This Rider
We provide the benefit stated in this rider as a part of the certificate to which it is attached for the person(s) shown on the Rider Schedule, subject to any limitations in this rider or the certificate.

Definitions

Abdominal Aortic Aneurysm Surgery means a surgical procedure that involves opening the abdomen and repairing or removing an abdominal aortic aneurysm.

Aortic Valve Replacement or Repair means a surgical procedure in which a covered person's aortic valve is repaired or replaced by a different valve.

Atherectomy means a procedure to open blocked coronary arteries or clears bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.

Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD) means the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient's chest where it monitors the heart's rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.

Balloon Angioplasty means a procedure which opens a clogged blood vessel. A thin tube is threaded through an artery to the narrowed heart vessel, where a small balloon at its tip is inflated. A balloon opens the narrowing by compressing atherosclerotic plaque against the vessel wall. The balloon is then deflated and removed.

Coronary Artery Bypass Graft Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts, excluding procedures such as, but not limited to, balloon angioplasty, valve replacement surgery, laser relief, stents or other non-surgical procedures.

Covered Heart Procedures means the following procedures defined in this rider:

- Abdominal Aortic Aneurysm Surgery
- Aortic Valve Replacement or Repair
- Mitral Valve Replacement or Repair
- Coronary Artery Bypass Graft Surgery
- Atherectomy
- Automatic Implantable (or internal) Cardioverter Defibrillator (AICD)
- Balloon Angioplasty
- Heart Catherization
- Laser Angioplasty
- Pacemaker Placement
- Stent Implantation
- Thrombectomy (clot removal) using catheters such as AngioJet

Heart Catherization means a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.

Laser Angioplasty means a procedure in which a laser tip is used to burn/break down plaque in the clogged blood vessel.

Mitral Valve Replacement or Repair means a surgical procedure in which a covered person's mitral valve is repaired or replaced by a different valve.

Pacemaker Placement means the initial placement/implantation of a pacemaker, which sends electrical signals to make the heart beat when a covered person's natural pacemaker is not working properly. This electrical device is placed under the skin. A lead extends from the device to the right side of the heart. Most pacemakers are used to correct a slow heart rate.

Stent Implantation means the implantation of a stainless steel mesh coil in a narrowed part of an artery to keep it propped open.

Thrombectomy (clot removal) using catheters such as AngioJet means a procedure that clears blood clots from coronary arteries before angioplasty and stenting. This delivers a high-pressure saline a high-pressure saline solution through the artery to the clot, breaking it up and simultaneously drawing it out.

Heart Benefits
We will pay this benefit if any covered person incurs a charge and is treated by a physician for a covered heart procedure defined in this rider if:

- it is performed as a result of one of the following: Acute Coronary Syndrome, Atherosclerosis, Coronary Artery Disease, Cardiomyopathy, or Valvular Heart Disease;
- the procedure is performed while this rider is in force; and
- the procedure is not excluded by name or specific description in this rider.

We will only pay for heart procedures specifically listed in this rider.

We will pay this benefit for each heart procedure only once per covered person per calendar year.

If two or more heart procedures occur on the same day, we will pay only one heart benefit. We will pay the larger of the two heart benefits.

EXCLUSIONS AND LIMITATIONS FOR COVERED HEART PROCEDURES

We will not pay benefits for a covered heart procedure that occurs as a result of a covered person's:

Felonies or Illegal Occupations
Committing or attempting to commit a felony or engaging in an illegal occupation.

Intoxicants and Narcotics
Being intoxicated or under the influence of any narcotic or voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the covered person's physician.

Suicide
Committing or trying to commit suicide or injuring oneself intentionally, whether sane or not.

War or Armed Conflict
Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.

[Pre-existing Condition Limitation
We will not pay the Heart Benefit for a covered heart procedure resulting from or affected by a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person undergoes a covered heart procedure.]

TERMINATION OF THE NAMED INSURED'S COVERAGE
The coverage on a named insured under this rider will terminate on the earliest of the following dates:

- the date coverage terminates under the certificate to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for the named insured;
- the date the named insured is no longer in an eligible class;
- the date the named insured's class is no longer included for insurance; or
- the date the next premium is due after the named insured asks us to end coverage.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while you are covered.

WHEN COVERAGE ENDS ON YOUR SPOUSE AND DEPENDENT CHILDREN
If this is a named insured and spouse coverage or two-parent family coverage, coverage on your spouse will end on the earliest of the following dates:

- the date the coverage terminates under the certificate to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for your spouse;
- the date the next premium is due after you ask us to end your spouse's coverage;
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled. If this is a named insured and spouse coverage or two-parent family coverage and you divorce your spouse, or your marriage is annulled and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which the covered person did not qualify.

If this is a one-parent family or two-parent family coverage, coverage on your dependent children will end on the earliest of the following dates:

- the date your coverage terminates under the certificate to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for your dependent children;
- the date the next premium is due after you ask us to end your dependent children's coverage;
- the date you die; or
- the date they no longer meet the definition of dependent children shown in the General Definitions section of the certificate.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while your spouse and/or dependent child is covered.

Coverage for your child may be continued past age 26 if your child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance. You must submit proof of the child's incapacity and dependency to us within 31 days of the child's 26th birthday. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year after the two-year period following the termination date. We will continue to charge any appropriate premium for that child as long as they meet the definition of a dependent child. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If this is one-parent family or two-parent family coverage and all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which they did not qualify.

[

Secretary]

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

INFECTIOUS DISEASES RIDER

RIDER SCHEDULE

Policyholder	[ABC Employer]	Group Policy Number:	[201141890 E111111]
Named Insured:	[John Doe]	Certificate Number:	[000000000]
Coverage Type:	[Two-Parent Family]	Rider Coverage Effective Date:	[01-01-2022]

BENEFIT FOR INFECTIOUS DISEASES

COVERED INFECTIOUS DISEASES:	**Percentage of Applicable Face Amount in the Certificate Schedule**
Antibiotic resistant bacteria (Including MRSA)	50%
Cerebrospinal Meningitis (Bacterial)	50%
Diphtheria	50%
Encephalitis	50%
Legionnaire's Disease	50%
Lyme Disease	50%
Malaria	50%
Necrotizing Fasciitis	50%
Osteomyelitis	50%
Poliomyelitis	50%
Rabies	50%
Sepsis	50%
Tetanus	50%
Tuberculosis	50%

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

[1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com]
A Stock Company

INFECTIOUS DISEASES RIDER

THIS IS A LIMITED RIDER - READ IT CAREFULLY.

THIS RIDER IS NOT ATTACHED TO A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

All terms, definitions of terms, conditions, exclusions and limitations for critical illness stated in the certificate will also apply to this rider unless we state otherwise in this rider.

Coverage Provided By This Rider
We will provide the benefit stated in this rider as a part of the certificate to which it is attached for the person(s) shown on the Rider Schedule, subject to any limitations in this rider or the certificate.

Infectious Diseases Benefit
We will pay this benefit if any covered person incurs a charge and is diagnosed by a physician with any of the covered infectious diseases on the Rider Schedule if:

- the date of diagnosis is while this rider is in force;
- the covered person is confined to a hospital for seven or more consecutive days for treatment of a covered infectious disease; and
- the infectious disease is not excluded by name or specific description in this rider.

Infectious Diseases means a severe infectious or contagious disease diagnosed by a physician that results in a covered person being confined to a hospital.

Infectious Diseases Date of Diagnosis is the date a physician confirms diagnosis of an infectious disease.

A **covered infectious disease** means one of the infectious or contagious diseases shown on the Rider Schedule.

We will only pay for infectious diseases specifically listed in this rider.

We will pay this benefit for each covered infectious disease only once per covered person per lifetime.

EXCLUSIONS AND LIMITATIONS FOR INFECTIOUS DISEASES

We will not pay benefits for a covered infectious disease that occurs as a result of a covered person's:

Felonies or Illegal Occupations
Committing or attempting to commit a felony or engaging in an illegal occupation.

Intoxicants and Narcotics
Being intoxicated or under the influence of any narcotic or voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the covered person's physician.

Suicide
Committing or trying to commit suicide or injuring oneself intentionally, whether sane or not.

War or Armed Conflict
Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.

[Pre-existing Condition Limitation
We will not pay the Infectious Diseases Benefit for a covered infectious disease that is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a covered infectious disease**.]**

TERMINATION OF THE NAMED INSURED'S COVERAGE
The coverage on a named insured under this rider will terminate on the earliest of the following dates:

- the date coverage terminates under the certificate to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for the named insured;
- the date the named insured is no longer in an eligible class;
- the date the named insured's class is no longer included for insurance; or
- the date the next premium is due after the named insured asks us to end coverage.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while you are covered.

WHEN COVERAGE ENDS ON YOUR SPOUSE AND DEPENDENT CHILDREN
If this is a named insured and spouse coverage or two-parent family coverage, coverage on your spouse will end on the earliest of the following dates:

- the date the coverage terminates under the certificate to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for your spouse;
- the date the next premium is due after you ask us to end your spouse's coverage;
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled. If this is a named insured and spouse coverage or two-parent family coverage and you divorce your spouse or your marriage is annulled and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which the covered person did not qualify.

If this is a one-parent family or two-parent family coverage, coverage on your dependent children will end on the earliest of the following dates:

- the date your coverage terminates under the certificate to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for your dependent children;
- the date the next premium is due after you ask us to end your dependent children's coverage;
- the date you die; or
- the date they no longer meet the definition of dependent children shown in the General Definitions section of the certificate.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while your spouse and/or dependent child is covered.

Coverage for your child may be continued past age 26 if your child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance. You must submit proof of the child's incapacity and dependency to us within 31 days of the child's 26th birthday. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year after the two-year period following the termination date. We will continue to charge any appropriate premium for that child as long as they meet the definition of a dependent child. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If this is one-parent family or two-parent family coverage and all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which they did not qualify.

[

Secretary]

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

PROGRESSIVE DISEASES RIDER

RIDER SCHEDULE

Policyholder	[ABC Employer]	Group Policy Number:	[201141890 E111111]
Named Insured:	[John Doe]	Certificate Number:	[000000000]
Coverage Type:	[Two-Parent Family]	Rider Coverage Effective Date:	[01-01-2022]
Elimination Period:	90 days		

BENEFIT FOR PROGRESSIVE DISEASES

COVERED PROGRESSIVE DISEASES:	**Percentage of Applicable Face Amount in the Certificate Schedule**
Amyotrophic Lateral Sclerosis (ALS)	[100%]
Dementia (Including Alzheimer's Disease)	[100%]
Huntington's Disease	[100%]
Lupus	[100%]
Multiple Sclerosis (MS)	[100%]
Muscular Dystrophy	[100%]
Myasthenia Gravis	[100%]
Parkinson's Disease	[100%]
Systemic Sclerosis (Scleroderma)	[100%]

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

[1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com]
A Stock Company

PROGRESSIVE DISEASES RIDER

THIS IS A LIMITED RIDER - READ IT CAREFULLY.

THIS RIDER IS NOT ATTACHED TO A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

All terms, definitions of terms, conditions, exclusions and limitations for critical illness stated in the certificate will also apply to this rider unless we state otherwise in this rider.

Coverage Provided By This Rider
We will provide the benefit stated in this rider as a part of the certificate to which it is attached for the person(s) shown on the Rider Schedule, subject to any limitations in this rider or the certificate.

Definitions
Activities of Daily Living (ADLs) means the following activities:

- ***Bathing*** means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- ***Continence*** means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- ***Dressing*** means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- ***Eating*** means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- ***Toileting*** means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- ***Transferring*** means the ability to move in or out of a chair, bed or wheelchair.

The covered person will not be considered unable to perform the ADL if the covered person can perform the ADL using equipment or adaptive devices and does not require substantial assistance in order to do so.

Amyotrophic Lateral Sclerosis (ALS) means a nervous system disease that causes muscle weakness and impacts physical function. ALS, also known as Lou Gehrig's disease, causes nerve cells to gradually break down and die.

Amyotrophic Lateral Sclerosis (ALS) Date of Diagnosis is the date the covered person is unable to perform two or more activities of daily living due to Amyotrophic Lateral Sclerosis (ALS) as diagnosed by a physician.

Cognitively Impaired or **Cognitive Impairment** means a deterioration or loss in intellectual capacity that requires another person's stand-by assistance or verbal cueing for an insured's protection or for the protection of others. It is measured by clinical evidence and standardized tests which reliably measure impairment in:

- short or long term memory;
- orientation to people, places, or time; or
- deductive or abstract reasoning.

Dementia (Including Alzheimer's Disease) means a progressive, degenerative disorder that attacks the brain's nerve cells or neurons, and may result in loss of memory, thinking, language skills, or behavioral changes.

Dementia (Including Alzheimer's Disease) Date of Diagnosis is the date the covered person is unable to perform two or more activities of daily living or is cognitively impaired due to Dementia (including Alzheimer's Disease) as diagnosed by a physician.

Elimination period means 90 consecutive days beginning from the date the covered person has been certified with a progressive disease in a manner acceptable to us. No benefits are payable for care or service received during this time.

Huntington's Disease means a hereditary disease characterized by gradual loss of brain function and voluntary movement due to degenerative changes in the cerebral cortex and basal ganglia.

Huntington's Disease Date of Diagnosis is the date the covered person is unable to perform two or more activities of daily living due to Huntington's Disease as diagnosed by a physician.

Lupus means an autoimmune disease where the body's immune system attacks healthy tissue, leading to long-term inflammation. This disease is primarily characterized by joint pain and swelling.

Lupus Date of Diagnosis is the date the covered person is unable to perform two or more activities of daily living due to Lupus as diagnosed by a physician.

Multiple Sclerosis (MS) means a chronic disease involving damage to the protective sheaths of nerve cells in the brain and spinal cord. Symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue. Eventually, the disease can cause the nerves themselves to deteriorate or become permanently damaged.

Multiple Sclerosis (MS) Date of Diagnosis is the date the covered person is unable to perform two or more activities of daily living due to Multiple Sclerosis (MS) as diagnosed by a physician.

Muscular Dystrophy means a genetic disease that causes progressive weakness and degeneration in the musculoskeletal system and where such muscles are replaced by scar tissue and fat. Muscular Dystrophy is characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissues.

Muscular Dystrophy Date of Diagnosis is the date the covered person is unable to perform two or more activities of daily living due to Muscular Dystrophy as diagnosed by a physician.

Myasthenia Gravis means a disease characterized by progressive weakness and exhaustibility of voluntary muscles without atrophy or sensory disturbance and caused by an autoimmune attack on acetylcholine receptors at the neuromuscular junction.

Myasthenia Gravis Date of Diagnosis is the date the covered person is unable to perform two or more activities of daily living due to Myasthenia Gravis as diagnosed by a physician.

Parkinson's Disease means a disease of the nervous system marked by tremor, muscular stiffness, and slow, imprecise movement. It is associated with degeneration of the basal ganglia of the brain and a deficiency of the neurotransmitter dopamine.

Parkinson's Disease Date of Diagnosis is the date the covered person is unable to perform two or more activities of daily living due to Parkinson's Disease as diagnosed by a physician.

Systemic Sclerosis (Scleroderma) means a progressive autoimmune disease characterized by the hardening and tightening of the skin and connective tissues.

Systemic Sclerosis (Scleroderma) Date of Diagnosis is the date the covered person is unable to perform two or more activities of daily living due to Systemic Sclerosis (Scleroderma) as diagnosed by a physician.

Progressive Diseases Benefit
We will pay this benefit if any covered person incurs a charge and is diagnosed by a physician with any of the progressive diseases on the Rider Schedule if:

- the covered person is unable to perform two or more activities of daily living;
- the date of diagnosis is while this rider is in force;
- the elimination period has been met; and
- the progressive disease is not excluded by name or specific description in this rider.

We will only pay for progressive diseases specifically listed in this rider.

We will pay this benefit for each progressive disease only once per covered person per lifetime.

EXCLUSIONS AND LIMITATIONS FOR PROGRESSIVE DISEASES

We will not pay benefits for a covered progressive disease that occurs as a result of a covered person's:

Felonies or Illegal Occupations
Committing or attempting to commit a felony or engaging in an illegal occupation.

Intoxicants and Narcotics
Being intoxicated or under the influence of any narcotic or voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the covered person's physician.

Suicide
Committing or trying to commit suicide or injuring oneself intentionally, whether sane or not.

War or Armed Conflict
Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.

[Pre-existing Condition Limitation
We will not pay the Progressive Diseases Benefit for a covered progressive disease that is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a covered progressive disease**.]**

TERMINATION OF THE NAMED INSURED'S COVERAGE
The coverage on a named insured under this rider will terminate on the earliest of the following dates:

- the date coverage terminates under the certificate to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for the named insured;
- the date the named insured is no longer in an eligible class;
- the date the named insured's class is no longer included for insurance; or
- the date the next premium is due after the named insured asks us to end coverage.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while you are covered.

WHEN COVERAGE ENDS ON YOUR SPOUSE AND DEPENDENT CHILDREN
If this is a named insured and spouse coverage or two-parent family coverage, coverage on your spouse will end on the earliest of the following dates:

- the date the coverage terminates under the certificate to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for your spouse;
- the date the next premium is due after you ask us to end your spouse's coverage;
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled. If this is a named insured and spouse coverage or two-parent family coverage and you divorce your spouse, or your marriage is annulled and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which the covered person did not qualify.

If this is a one-parent family or two-parent family coverage, coverage on your dependent children will end on the earliest of the following dates:

- the date your coverage terminates under the certificate to which this rider is attached;
- the end of the grace period following the premium due date and we do not receive the required premium for your dependent children;

- the date the next premium is due after you ask us to end your dependent children's coverage;
- the date you die; or
- the date they no longer meet the definition of dependent children shown in the General Definitions section of the certificate.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while your spouse and/or dependent child is covered.

Coverage for your child may be continued past age 26 if your child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance. You must submit proof of the child's incapacity and dependency to us within 31 days of the child's 26th birthday. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year after the two-year period following the termination date. We will continue to charge any appropriate premium for that child as long as they meet the definition of a dependent child. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If this is one-parent family or two-parent family coverage and all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which they did not qualify.

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Secretary]

ELECTION OF GROUP SPECIFIED DISEASE INSURANCE PORTABILITY COVERAGE
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
P.O. BOX 1365, COLUMBIA, SOUTH CAROLINA 29202 Phone: 1.800.325.4368

If your group coverage ends, we will provide specified disease insurance coverage, subject to the Portability provision in your Group Specified Disease certificate. To apply, you must complete this form and send it to us within 63 days after your Group Specified Disease coverage ends.

SECTION 1: APPLICANT/NAMED INSURED INFORMATION (to be completed by the applicant/named insured)

Insured Name (First, MI, Last)	Gender	Date of Birth (mm/dd/yyyy)	Social Security No.
John Doe	M ☒ F ☐	01/01/2019	555-55-5555

Home Address – Street	City	State	Zip Code	Primary Phone No.
123 Any Street	Any City	Any State	12345	555-555-5555

Email Address	Secondary Phone No.
jdoe@anyemail.com	555-555-5555

SECTION 2: POLICYHOLDER INFORMATION (to be completed by the employer/plan administrator)

Policyholder Name	Group Policy No.	Billing Control No.
ABC Company	1111111111	11111111

Policyholder Home Office Address - Street	City	State	Zip Code	Business Phone No.
123 Any Street	Any City	Any State	12345	555-555-5555

Reason for Coverage Termination / Reduction	Date of Termination (mm/dd/yyyy)
Any	01/01/2019

Policyholder Signature

(x)___*Any Employer*_____ Date: __12/01/2019_____
Employer/Plan Administrator (mm/dd/yyyy)

SECTION 3: COVERAGE ELECTIONS – NOTE: You may keep the same level of coverage or reduce the level of coverage. The named insured must port coverage to allow porting for a spouse/domestic partner or dependent children. Coverage election may only be changed to remove a spouse/domestic partner and/or dependent. Coverage election may not be changed to add spouse/domestic partner and/or dependents to coverage. **The minimum face amount for Group Specified Disease coverage is $5,000.**

☒ I elect to port my coverage with no changes.
☐ I elect to reduce my face amount of coverage to: $_____
☐ I elect to remove the following riders: ☐Cancer Benefits Rider ☐ First Diagnosis Building Benefit Rider ☐Heart Benefits Rider ☐Progressive Diseases Rider ☐Infectious Diseases Rider
☐ I elect to remove the following insureds from my coverage: ☐ Spouse/Domestic Partner ☐ Dependent Children

SECTION 4: PAYMENT SECTION – You have a choice of 2 payment methods, please select one.

1. ☐ **Please deduct monthly premiums from my bank account.**
☐1st - 5th ☐6th - 10th ☐11th - 15th ☐16th - 20th ☐21st - 26th

Your draft will occur on one of the dates within the range you have selected. Please include a voided check or provide:

Routing No._____

Account No. _____

_____
Signature of bank account owner

2. ☒ **Please bill me directly.** (Choose one of the following):

☒ Quarterly (3 times your monthly premium)
☐ Semi-Annual (6 times your monthly premium)
☐ Annual (12 times your monthly premium)

SECTION 5: AGREEMENT SECTION

I understand and agree to the following:

1. Any coverage chosen on this election form will be issued in accordance with the Portability provision contained in your Colonial Life & Accident Insurance Company Group Specified Disease certificate and is subject to satisfaction of the conditions provided therein.

2. Portability coverage will become effective the day after your Group Specified Disease coverage terminates subject to Colonial Life & Accident Insurance Company receiving a completed Election of Portability Coverage form and the first premium within 63 days from the date group coverage terminates.

(x)___ *John Doe* _____ Date: _12/01/2019_____
Applicant/Named Insured Signature (mm/dd/yyyy)

GROUP SPECIFIED DISEASE INSURANCE ENROLLMENT FORM
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO Box 1365, Columbia, SC 29202

ENROLLMENT TYPE

☒ Initial Enrollment ☐ New Hire ☐ Qualifying Event
Qualifying Event Date (mm/dd/yyyy): _____ Qualifying Event:_____

PROPOSED INSURED SECTION

Proposed Insured (First, MI, Last)	Gender	Date of Birth (mm/dd/yyyy)	Social Security No.
John Doe	M ☒ F ☐	01/01/1990	555-55-5555

Home Address – Street	City	State	Zip Code	Primary Phone No.
123 Any Street	Any City	Any State	12345	555-555-5555

Date of Hire	Occupation	Hrs Worked/Week	Annual Base Salary	Secondary Phone No.
01/2019	Any	40	$xx,xxxx	555-555-5555

Email Address
jdoe@anyemail.com

BILLING SECTION

Payroll Deduction Employer Name	Employee ID / Payroll No.	Employee Class	Section / Dept. No.
ABC Company			

SPOUSE/DOMESTIC PARTNER SECTION – Complete if applying for spouse/domestic partner coverage

Is your spouse/domestic partner applying for coverage? If yes, provide identifying information below. ☐Yes ☒No

Name of Spouse/Domestic Partner (First, MI, Last)	Gender	Date of Birth (mm/dd/yyyy)	Relationship	Social Security No.
	M ☐ F ☐			

DEPENDENT CHILDREN SECTION – Complete if applying for dependent children coverage

Are there any eligible dependent children applying for coverage? ☐Yes ☒No Number of Dependents:

BENEFICIARY SECTION – If additional space is needed use Additional Data Section

Beneficiary Name (First, MI, Last) and Address		
Sally Doe		☒ Primary ☐ Contingent
Beneficiary Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured	Benefit %
01/01/1991	spouse	100
Beneficiary Name (First, MI, Last) and Address		☐ Primary ☐ Contingent
Beneficiary Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured	Benefit %

PLAN SECTION

Type of Coverage	N=New T=Transfer	Base Plan Code	Base Units	Rider Plan Code(s)	P = Pre-Tax A = After-Tax	Total Monthly Premium
☒ Named Insured ☐ Named Insured & Spouse/Domestic Partner ☐ One-Parent Family ☐ Two-Parent Family	N	xxxx	xx	xxxx	P☐ A☒	$xx.xx

ELIGIBILITY SECTION	**Proposed Insured**
1. Within the past 12 months, has the proposed insured used tobacco in any form or any nicotine delivery system, including electronic devices, nicotine substitutes, or smoking cessation products, or any electronic device that does not contain nicotine including electronic vaporizers or cigarettes?	☐Yes ☒No
2a. Is the proposed insured actively working? If No, answer 2b. 2b. Is the proposed insured disabled or unable to work?	☒Yes ☐No ☐Yes ☐No
3. Do you have comprehensive health coverage? If no, you are not eligible for coverage.	Yes ☒ No ☐
4. Do you understand most supplemental only policies may not pay full benefits if the comprehensive major medical or comprehensive medical plan is **not** in force?	Yes ☒ No ☐
5. Do you understand that this is a supplemental only policy and that the benefits provided under this policy may be limited?	Yes ☒ No ☐

REPLACEMENT SECTION	**Proposed Insured**
6a. Will any insurance with this or any other company be replaced or changed if the coverage applied for is issued? If yes, provide company name, address, policy number and complete required replacement form, if applicable in your state, and complete 6b. 6b. If replacing existing coverage, please indicate if existing coverage is Colonial Life & Accident Insurance Company coverage or another carrier's coverage by checking the appropriate box. ☐ Colonial Life & Accident Insurance Company ☐ Other	☐Yes ☒No

Insurance Company Name and Address	**Policy Number(s)**

ADDITIONAL DATA SECTION For additional information provide details:

AGREEMENT SECTION

THE PROPOSED INSURED AGREES AS FOLLOWS:

All exceptions and limitations pertaining to the coverage(s) for which I have applied have been explained to me including any pertaining to pre-existing conditions. **WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.**

REQUEST FOR TRANSFER/CANCELLATION: In conjunction with my application for the coverage indicated, I hereby request cancellation of my Colonial Life & Accident Insurance Company Policy/Certificate Number(s) _____. Transfer or cancellation of the base plan will also mean cancellation of all attached riders. If for any reason the coverage applied for above is not issued, this request for cancellation shall be null and void.

Signed at: City_____Any City _____ State __Any State___ Date __12/01/2019_____
mm/dd/yyyy

(x)___*John Doe*_____
Signature of Proposed Insured

AGENT SECTION

I have explained to the proposed insured all exceptions and limitations pertaining to the coverage(s) applied for. I hereby certify that I know nothing affecting the insurability of the proposed insured, which is not fully set forth in this Enrollment form. I further certify that I am a licensed agent in the state where this Enrollment form is being taken. I understand that I do not have Colonial Life & Accident Insurance Company's authorization to accept risk, pass on insurability, or make void, waive or change any conditions or provisions of the Enrollment form, policy or certificate, as applicable.

Date__12/01/2019_____ x ___ *Joe Agent* _____
mm/dd/yyyy Signature of Licensed Agent (full name as it appears on license)

Agent Name_____Joe Agent_____ License No.__12345_____ Code No._67890_____

GROUP SPECIFIED DISEASE INSURANCE EVIDENCE OF INSURABILITY FORM
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO Box 1365, Columbia, SC 29202

ENROLLMENT TYPE

☒Initial Enrollment ☐New Hire ☐Late Entrant ☐ Qualifying Event
Qualifying Event Date (mm/dd/yyyy): _____ Qualifying Event:_____

PROPOSED INSURED SECTION

Proposed Insured (First, MI, Last)	Gender	Date of Birth (mm/dd/yyyy)	Social Security No.
John Doe	M ☒ F ☐	01/01/1990	555-55-5555

Home Address – Street	City	State	Zip Code	Primary Phone No.
123 Any Street	Any City	Any State	12345	555-555-5555

Date of Hire	Occupation	Hrs Worked/Week	Annual Base Salary	Secondary Phone No.
01/2019	Any	40	$xx,xxxx	555-555-5555

Email Address
jdoe@anyemail.com

BILLING SECTION

Payroll Deduction Employer Name	Employee ID / Payroll No.	Employee Class	Section / Dept. No.
ABC Company			

SPOUSE/DOMESTIC PARTNER SECTION – Complete if applying for spouse/domestic partner coverage

Is your spouse/domestic partner applying for coverage? If yes, provide identifying information below. ☐Yes ☒No

Name of Spouse/Domestic Partner (First, MI, Last)	Gender	Date of Birth (mm/dd/yyyy)	Relationship	Social Security No.
	M ☐ F ☐			

DEPENDENT CHILDREN SECTION – Complete if applying for dependent children coverage

Are there any eligible dependent children applying for coverage? ☐Yes ☒No | Number of Dependents:

BENEFICIARY SECTION – If additional space is needed use Additional Data Section

Beneficiary Name (First, MI, Last) and Address		
Sally Doe		☒ Primary ☐ Contingent
Beneficiary Date of Birth (mm/dd/yyyy) 01/01/1991	Relationship to Proposed Insured Spouse	Benefit % 100
Beneficiary Name (First, MI, Last) and Address		☐ Primary ☐ Contingent
Beneficiary Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured	Benefit %

PLAN SECTION

Type of Coverage	N=New T=Transfer	Base Plan Code	Base Units	Rider Plan Code(s)	P = Pre-Tax A = After-Tax	Total Monthly Premium
☒ Named Insured ☐ Named Insured & Spouse/Domestic Partner ☐ One-Parent Family ☐ Two-Parent Family	N	xxxx	xx	xxxx	P☐ A☒	$xx.xx

ELIGIBILITY SECTION	Proposed Insured
1. Within the past 12 months, has the proposed insured used tobacco in any form or any nicotine delivery system, including electronic devices, nicotine substitutes, or smoking cessation products, or any electronic device that does not contain nicotine including electronic vaporizers or cigarettes?	☐Yes ☒No
2a. Is the proposed insured actively working? If No, answer 2b. 2b. Is the proposed insured disabled or unable to work?	☒Yes ☐No ☐Yes ☐No
3. Do you have comprehensive health coverage? If no, you are not eligible for coverage.	Yes ☒ No ☐
4. Do you understand most supplemental only policies may not pay full benefits if the comprehensive major medical or comprehensive medical plan is **not** in force?	Yes ☒ No ☐
5. Do you understand that this is a supplemental only policy and that the benefits provided under this policy may be limited?	Yes ☒ No ☐

REPLACEMENT SECTION	Proposed Insured
6a. Will any insurance with this or any other company be replaced or changed if the coverage applied for is issued? If yes, provide company name, address, policy number and complete required replacement form, if applicable in your state, and complete 6b. 6b. If replacing existing coverage, please indicate if existing coverage is Colonial Life & Accident Insurance Company coverage or another carrier's coverage by checking the appropriate box. ☐ Colonial Life & Accident Insurance Company ☐ Other	☐Yes ☒No
Insurance Company Name and Address	**Policy Number(s)**

AIDS SECTION	Proposed Insured	Spouse/ Domestic Partner	Dependent(s)
7. Has anyone applying for coverage tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No

Any Dependent with a "Yes" answer to question 7 must be listed below and will be excluded under the Group Specified Disease Insurance certificate to which a copy of this Evidence of Insurability form is attached. If additional space is needed use, Additional Data Section.

Name (First, MI, Last)	Relationship to Proposed Insured	Date of Birth (mm/dd/yyyy)	Social Security No.

PROGRESSIVE DISEASES RIDER SECTION – Complete questions 8 and 9 if applying for Progressive Diseases Rider.	Proposed Insured	Spouse/ Domestic Partner	Dependent(s)
8. Has anyone applying for coverage ever been diagnosed with, received medical advice or treatment, including medication, by a member of the medical profession for: Disease or disorder of the central nervous system Parkinson's Disease Alzheimer's Disease Dementia Senility Organic brain syndrome Muscular Dystrophy (MD) Lou Gehrig's Disease (ALS) Multiple Sclerosis (MS) Lupus Myasthenia Gravis Huntington's Chorea Systemic Sclerosis (Scleroderma)	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No
9. In the last 2 years, has anyone applying for coverage had a prolonged state of unconsciousness lasting more than 48 hours?	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No

Any Dependent with a "Yes" answer to questions 8 or 9 must be listed below and will be excluded under the Group Specified Disease Insurance certificate to which a copy of this Evidence of Insurability form is attached. If additional space is needed use, Additional Data Section.

Name (First, MI, Last)	Relationship to Proposed Insured	Date of Birth (mm/dd/yyyy)	Social Security No.

SIMPLIFIED ISSUE – Complete only questions 10-12 for Cancer. Complete only question 13 for Critical Illness.	Proposed Insured	Spouse/ Domestic Partner	Dependent(s)
10. Within the past 5 years, has anyone applying for coverage been diagnosed with, received medical advice or treatment, including medication, by a member of the medical profession for internal cancer, leukemia or melanoma Stage 2 or higher?	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No
11. Within the past 12 months, has anyone applying for coverage received hormonal therapy in conjunction with cancer treatment or preventative hormonal therapy following cancer treatment?	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No
12. Within the past 5 years, has anyone applying for coverage been diagnosed with, received medical advice or treatment, including medication, by a member of the medical profession for skin cancer, including basal cell carcinoma, squamous cell carcinoma, or melanoma in situ or Stage 1?	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No

Any Proposed Insured, Spouse/Domestic Partner or Dependents with a "Yes" answer to question 12 must be listed below and Skin Cancer benefits will be excluded for a period of 5 years from the effective date of the coverage under the Group Specified Disease Insurance certificate to which a copy of this Evidence of Insurability form is attached. If additional space is needed use Additional Data Section.

Name (First, MI, Last)	Relationship to Proposed Insured	Date of Birth (mm/dd/yyyy)	Social Security No.

SIMPLIFIED ISSUE – continued	Proposed Insured	Spouse/ Domestic Partner	Dependent(s)
13. Within the past 10 years, has anyone applying for coverage been diagnosed with, received medical advice or treatment, including medication, by a member of the medical profession for: Heart Attack (MI) — Cardiovascular or Circulatory Surgery Heart Surgery — Blood Pressure Reading of 160/100 or above Heart Disease or Disorder — Kidney Disease or Disorder, except stones Heart Failure — Diabetes diagnosed prior to age 40 Chest Pain/Angina — Insulin Dependent Diabetes Congestive Heart Failure — Glaucoma Abnormal Catherization — Retinitis Pigmentosa Cardiomyopathy — Macular Degeneration Stroke — Emphysema Transient Ischemic Attack (TIA) — Chronic Obstructive Pulmonary Disease (COPD) Peripheral Vascular Disease (PVD) — Liver Disease or Disorder Organ Transplant — Hepatitis B or C	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No

Any Dependent with a "Yes" answer to questions 10, 11 or 13 must be listed below and will be excluded under the Group Specified Disease Insurance certificate to which a copy of this Evidence of Insurability form is attached. If additional space is needed use, Additional Data Section.

Name (First, MI, Last)	Relationship to Proposed Insured	Date of Birth (mm/dd/yyyy)	Social Security No.

SIMPLIFIED ISSUE LEVEL 1 - Complete only question 14 for Cancer. Complete only questions 15-17 for Critical Illness.	Proposed Insured	Spouse/ Domestic Partner	Dependent(s)
14. Within the last 12 months, has anyone applying for coverage been diagnosed with, received medical advice or treatment, including medication, by a member of the medical profession for internal cancer**,** leukemia or melanoma Stage 2 or higher? If yes, provide details in the Additional Data Section.	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No
15. Indicate Current Height/Weight (Proposed Insured and spouse/domestic partner, if spouse/domestic partner coverage applied for) Proposed Insured: Height _____ Weight_____ Spouse/Domestic Partner: Height _____ Weight_____			
16**.** Is anyone applying for coverage currently prescribed any medication? If yes, provide details in the Additional Data Section.	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No
17. Within the last 5 years, has anyone applying for coverage been diagnosed with, received medical advice, treatment, including medication, by a member of the medical profession, or had surgery or an abnormal diagnostic test for any disease, mental or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this application? If yes, please provide details in the Additional Data Section.	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No
[SIMPLIFIED ISSUE LEVEL 2 – Complete only questions 18 and 19 for Cancer. Complete question only 20 for Critical Illness.	**Proposed Insured**	**Spouse/ Domestic Partner**	**Dependent(s)**
18. Has anyone applying for coverage [ever] been diagnosed with, received medical advice or treatment, including medication, by a member of the medical profession for internal cancer**,** leukemia or melanoma Stage 2 or higher? If yes, provide details in the Additional Data Section.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
19. Has anyone applying for coverage [ever] received hormonal therapy in conjunction with cancer treatment or preventative hormonal therapy following cancer treatment?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
20. Has anyone applying for coverage [ever] been diagnosed with, received medical advice or treatment, including medication, by a member of the medical profession for any of the following? If yes, provide details in Additional Data Section. Heart Disease — Cancer Circulatory Disease — Kidney Disease Blood pressure reading of 160/100 or above — Cirrhosis or Liver Disease Lung Disease — Hepatitis B or C Respiratory Disease	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No]

ADDITIONAL DATA SECTION For yes answers to health-related questions or additional information provide details:

Condition Name/ Medication Name & Dosage	Diagnosis Date & Duration	Doctor/Hospital Name, Address & Phone No.	Date of Treatment	Type of Treatment Received

ADDITIONAL DATA SECTION For additional non-health information provide details:

AGREEMENT SECTION

THE PROPOSED INSURED AGREES AS FOLLOWS:

All exceptions and limitations pertaining to the coverage(s) for which I have applied have been explained to me including any pertaining to pre-existing conditions. **WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.**

REQUEST FOR TRANSFER/CANCELLATION: In conjunction with my application for the coverage indicated, I hereby request cancellation of my Colonial Life & Accident Insurance Company Policy/Certificate Number(s) _____. Transfer or cancellation of the base plan will also mean cancellation of all attached riders. If for any reason the coverage applied for above is not issued, this request for cancellation shall be null and void.

Signed at: City___Any City _____ State __Any State___ Date ___12/01/2019_____
mm/dd/yyyy

(x)____ *John Doe* _____
Signature of Proposed Insured

AGENT SECTION

I have explained to the proposed insured all exceptions and limitations pertaining to the coverage(s) applied for. I hereby certify that I know nothing affecting the insurability of the proposed insured, which is not fully set forth in this Evidence of Insurability form. I further certify that I am a licensed agent in the state where this Evidence of Insurability form is being taken. I understand that I do not have Colonial Life & Accident Insurance Company's authorization to accept risk, pass on insurability, or make void, waive or change any conditions or provisions of the Evidence of Insurability form, policy or certificate, as applicable.

Date__12/01/2019_____ x ____ *Joe Agent*_____
mm/dd/yyyy Signature of Licensed Agent (full name as it appears on license)

Agent Name__Joe Agent_____ License No.__12345_____ Code No._67890_____

Colonial Life & Accident Insurance Company
Supplemental Data Form

To be made a part of application form number GCI6000 Enroll or GCI6000 E of I, including state abbreviations where applicable.

Proposed Insured Name (First, MI, Last) John Doe	Social Security No. 111-11-1111
Payroll Deduction Employer Name Any Account	Billing Control No. 55555555

Any overflow data

The statements and answers on this supplement to the application are true and complete to the best of my knowledge and belief. I agree that they shall form a part of my application and any certificate issued thereunder.

John Doe _____ _____ 01/01/2018

Signature of Proposed Insured | Signature of Owner (If other than Proposed Insured) | Date (MM/DD/YYYY)

I hereby certify that I have truthfully and accurately recorded on this supplement to the application the information supplied by the Proposed Insured. I further certify that I am a licensed agent in the state where this application is being taken.

Joe Agent _____ 01/01/2018

Signature of Licensed Agent | Date (MM/DD/YYYY)

State: District of Columbia **Filing Company:** Colonial Life & Accident Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Group Critical Illness/Cancer
Project Name/Number: Group Critical Illness/Cancer /GCI6000

Rate Information

Rate data applies to filing.

Filing Method:
Rate Change Type: %
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision:
Filing Method of Last Filing: 0
SERFF Tracking Number of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Colonial Life & Accident Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	%

State: District of Columbia **Filing Company:** Colonial Life & Accident Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Group Critical Illness/Cancer
Project Name/Number: Group Critical Illness/Cancer /GCI6000

Supporting Document Schedules

Satisfied - Item:	Statements of Variability
Comments:	
Attachment(s):	GCI6000 Statement of Variability - DC.pdf Underwriting Statement of Variability - DC.pdf
Item Status:	APPROVED
Status Date:	02/06/2020

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Readability Compliance Certification - DC - Completed.pdf
Item Status:	APPROVED
Status Date:	02/06/2020

Satisfied - Item:	DC Guaranty Notice
Comments:	
Attachment(s):	DC Guaranty Notice 45663-4.pdf
Item Status:	APPROVED
Status Date:	02/06/2020

Satisfied - Item:	Cover Letter
Comments:	
Attachment(s):	GCI6000 Submission Letter - DC.pdf
Item Status:	APPROVED
Status Date:	02/06/2020

Satisfied - Item:	2/6/2020 Resubmission Letter
Comments:	
Attachment(s):	GCI6000-DC 1.31.2020 Resubmission Letter.pdf
Item Status:	APPROVED
Status Date:	02/06/2020

STATEMENT OF VARIABILITY for forms: GCI6000-P, GCI6000-C-DC, R-GCI6000-CB, R-GCI6000-BB, R-GCI6000-HB-DC, R-GCI6000-INF-DC and R-GCI6000-PD-DC

MASTER POLICY, GCI6000-P

FACE PAGE	
Company, address, phone number and website address	Company address, phone number and website address may be modified on any forms included in this filing, if changes occur in the future.
Coverage Type	Specified Disease coverage may refer to: Critical Illness Benefits and Cancer Benefits or Critical Illness Benefits only or Cancer Benefits only as the type of coverage or benefits provided.
Disclosure Statement	Disclosure Statement may be modified or removed based on legislative changes, if required changes occur in the future.
Employee Retirement Income Security Act of 1974 (ERISA) language	ERISA language will be included in employer accounts and will either appear as shown or not at all. No text will be changed within the brackets.
Officer Signatures	Officer signatures and titles are subject to updates as officer's names and/or titles change.
Page 3 - 10 – POLICY RATE SCHEDULE	
Policyholder, Policy Number, Policyholder Address, Billing Control Number, Policy Effective Date, Governing Jurisdiction, First Policy Anniversary	Will change with each policyholder.
Description of Eligible Classes	Minimum hours per week is policyholder specific but will usually range between 15-30 hours. Definitions such as active employment, material and substantial duties, and regular occupation will be included or deleted as appropriate. These definitions may alternatively include association or union terms, as appropriate. Policyholders may be employer, association or union groups. [**Class 1** Active employees working at least [1,000] hours per [year].] The bracketed [year] may be changed to day, week, month, quarter [**Class 2** A named insured in good standing with [ABC] Association/Union] [**Class 3** A named insured in good standing with [ABC] Union working full-time for a policyholder who is contributing to the group policy] [**Class 4** A named insured who has ported coverage] [**Class 5** Active employees who retire.]

	[Class 2] [and] [Class 3] To be eligible for insurance under this policy you must be a member of an eligible class. • [If you are in an eligible class on the date insurance becomes available for the class, you will be eligible for insurance on the date you complete any applicable eligibility period set by the policyholder.] • [If you are in an eligible class on the date insurance becomes available for the class, you will be eligible for insurance on the [date] [[1st-31st] day of the Calendar Month coinciding with or next following the date] that insurance becomes available for the class.] • [If you enter an eligible class after the date insurance becomes available to members of that class, you will be eligible for insurance on the date you complete any applicable eligibility period set by the policyholder.] • [If you enter an eligible class after the date insurance is made available to the members of that class, you will be eligible for insurance on the [date] [1st-31st] day of the Calendar Month coinciding with or next following the date you enter the eligible class.]
New Hire Waiting Period	[0 - 365] days. This is determined by the policyholder.
New Hire Eligibility Period	[0 - 365] days. This is determined by the policyholder.
BENEFIT AMOUNT	
Face Amount for Named Insured	Benefit amount for Named Insured can range from **$1,000 - $150,000**.
Face Amount for Spouse	Benefit Amount for Spouse may or may not be available, based on the policyholder's plan. Spouse coverage can range from **$500 - $150,000** If spouse coverage is not selected, the entire line will not appear
Face Amount for Dependent Children	Benefit for dependent children coverage may or may not be available based on the policyholder's plan. Dependent children coverage can range from **$500 - $300,000.**

	If child coverage is not selected, the entire line will not appear
Additional Face Amount for Named Insured	Based on the policyholder's plan, the named insured may have the option to purchase additional face amounts (buy-up) for himself, spouse or dependent, in addition to the policyholder's plan.
POLICYHOLDER PLAN CHOICE FOR CRITICAL ILLNESS BENEFIT:	
Critical Illness Benefit	Benefit will appear as shown or not based policyholder choice
POLICYHOLDER PLAN ADDITIONAL CRITICAL ILLNESS BENEFIT FOR DEPENDENT CHILDREN BENEFIT:	
Additional Critical Illness Benefit for Dependent Children	Benefit will appear as shown or not based policyholder choice
POLICYHOLDER PLAN CHOICE FOR CANCER BENEFITS:	
Cancer Benefits	Benefits will appear as shown or not based policyholder choice
POLICYHOLDER PLAN CHOICE FOR WELLBEING ASSISTANCE BENEFIT:	
Wellbeing Assistance Benefit	Optional benefit and will appear as shown or not based on policyholder choice and the amount can be [$25 - $300] in $25 increments
RIDERS	
Cancer Benefits Rider, First Diagnosis Building Benefit Rider, Heart Benefits Rider, Infectious Diseases Rider and Progressive Diseases Rider	Riders may or may not be included based on the policyholder's choice.
RATES	
Initial Monthly Rates	The initial monthly rates will be based upon the actual cost of coverage chosen. Rates will vary based on coverage selected. The coverage can be rated on a composite rate structure, issue age bands or attained aged rates based on tobacco, non-tobacco or uni-tobacco class on the policyholder's plan. We will display the appropriate rate table depending on the rate structure such as Attained Age, Issue Age, or Composite Rate. When rates are calculated on a Non-tobacco or Tobacco basis, the appropriate headers will be reflected. The bracketed ages may vary by 5-year standard or 10-year standard. Initial Monthly Rates for the Cancer Benefits Rider will have more than one schedule for [Level 1] [Level 2] and [Level 3].
Rate Guarantee Period	Will be either: **one**, **two**, **three**, **four** or **five years**.
Divisions, subsidiaries or affiliated companies	Will be listed as appropriate
Page – 11 – 14 - POLICYHOLDER PROVISIONS	
Our Right to Change Premiums	Options for prior notification dates are [45, 60, 90, 120, and 180] days. The standard is based on the state requirements
Termination of This Contract	Options for prior notification dates are [45, 60, 90, 120, and 180] days.

CERTIFICATE, GCI6000-C-DC

FACE PAGE	
Company, address, phone number and website address	Company address, phone number and website address may be modified on any forms included in this filing, if changes occur in the future
Coverage Type	Specified Disease coverage may refer to: Critical Illness Benefits and Cancer Benefits or Critical Illness Benefits only or Cancer Benefits only as the type of coverage or benefits provided based on policyholder choice
Disclosure Statement	Disclosure Statement may be modified or removed based on legislative changes, if required changes occur in the future
Employee Retirement Income Security Act of 1974 (ERISA) language	ERISA language will be included in employer accounts and will either appear as shown or not at all. No text will be changed within the brackets.
Officer Signatures	Officer signatures and titles are subject to updates as officer's names and/or titles change
SECTION 2 - CERTIFICATE GUIDE	
Section 5 - Definitions for Critical Illness Benefit **Section 6 - Additional Critical Illness Benefit for Dependent Children** **Section 7- Definitions for Cancer Benefits**	Definition sections will appear or not based on the benefits selected the policyholder The section numbers will change as sections are added or deleted, as appropriate.
Section 9 - Critical Illness Benefit **Section 10 - Additional Critical Illness Benefit for Dependent Children** **Section 11 - Cancer Benefits**	Benefits sections will appear or not based on the benefits selected by the policyholder The section numbers will change as sections are added or deleted, as appropriate
Section 12 Wellbeing Assistance Benefit	Optional benefit and will appear as shown or not at all based on policyholder choice The section numbers will change as sections are added or deleted, as appropriate
Section 13 Exclusions and Limitations for Critical Illness **Section 14 Exclusions and Limitations for Cancer**	Exclusions and Limitations sections will appear or not based on the benefits selected by the policyholder The section numbers will change as sections are added or deleted, as appropriate
Section 18 Portability	The entire section will be removed in plans with no portability option. The section numbers will change as sections are added or deleted, as appropriate
CERTIFICATE SCHEDULE	
Policyholder, Certificate Number, Named Insured, Billing Control Number, Coverage	Will vary by policyholder and named insured

Effective Date, Premium Class and Coverage Type	
Pre-Existing Condition Limitation Period	Will be shown as is, or not at all if pre-existing conditions are waived
BENEFIT AMOUNT	
Face Amount for Named Insured	Benefit amount for Named Insured can range from **$1,000 - $150,000**
Face Amount for Spouse	Benefit Amount for Spouse may or may not be available, based on the policyholder's plan. Spouse coverage can range from **$500 - $150,000** If spouse coverage is not selected, the entire line will not appear
Face Amount for Dependent Children	Benefit for dependent children coverage may or may not be available based on the policyholder's plan. Dependent children coverage can range from **$500 - $300,000** If child coverage is not selected, the entire line will not appear
Additional Face Amount for Named Insured	Based on the policyholder's plan, the named insured may have the option to purchase additional face amounts (buy-up) for himself, spouse or dependent, in addition to the policyholder's plan
BENEFIT FOR CRITICAL ILLNESS	
Critical Illness Benefit	A policyholder can choose to include or exclude the Critical Illness Benefit
BENEFIT FOR ADDITIONAL CRITICAL ILLNESS FOR DEPENDENT CHILDREN	
Additional Critical Illness Benefit for Dependent Children	A policyholder can choose to include or exclude the Additional Critical Illness Benefit for Dependent Children.
BENEFITS FOR CANCER	
Cancer Benefits	A policyholder can choose to include or exclude Cancer Benefits
WELLBEING ASSISTANCE BENEFIT	
Wellbeing Assistance Benefit	A policyholder can choose to include or exclude the Wellbeing Assistance benefit and the amount can be [$25 - $300] in $25 increments
SECTION 4 – GENERAL DEFINITIONS	Definitions may be added or removed according to a policyholder's plan
Pre-Existing Condition	Will be shown as is, or not at all if pre-existing conditions are waived
SECTION 5 – DEFINITIONS FOR CRITICAL ILLNESS BENEFIT	This section may be added or removed according to a policyholder's plan
SECTION 6 – DEFINITIONS FOR ADDITIONAL CRITICAL ILLNESS BENEFIT FOR DEPENDENT CHILDREN	This section may be added or removed according to a policyholder's plan
SECTION 7 – DEFINITIONS FOR CANCER BENEFITS -	This section may be added or removed according to a policyholder's plan
SECTION 8 – ELIGIBILITY AND EFFECTIVE DATE	The section number will vary based on the policyholder's plan

SECTION 9 – BENEFIT FOR CRITICAL ILLNESS	Benefit will either appear as shown or not at all depending on the plan chosen by the policyholder
2nd bullet that begins "[the critical illness diagnosed during the 12 months…."	Will be shown as is, or not at all if pre-existing conditions are waived
2nd paragraph that begins "[We will not pay the Critical Illness Benefit…."	Will be shown as is, or not at all if pre-existing conditions are waived
SECTION 10 – ADDITIONAL CRITICAL ILLNESS BENEFIT FOR DEPENDENT CHILDREN	Benefit will either appear as shown or not at all depending on the plan chosen by the policyholder
Additional Critical Illness Benefit for Dependent Children	
1st bullet that begins "[the additional critical illness for dependent children diagnosed during the 12 months…."	Will be shown as is, or not at all if pre-existing conditions are waived
2nd paragraph that begins "[We will not pay the Additional Critical Illness Benefit for Dependent Children…."	Will be shown as is, or not at all if pre-existing conditions are waived
SECTION 11 – CANCER BENEFITS	Benefits will either appear as shown or not at all depending on the plan chosen by the policyholder
Invasive Cancer (Including All Breast Cancer) Benefit	
2nd bullet that begins "[the invasive cancer is diagnosed during the 12 months…."	Will be shown as is, or not at all if pre-existing conditions are waived
3rd paragraph that begins "[We will not pay the Invasive Cancer (Including all Breast Cancer) Benefit…."	Will be shown as is, or not at all if pre-existing conditions are waived
Non-Invasive Cancer Benefit	
2nd bullet that begins "[the non-invasive cancer is diagnosed during the 12 months…."	Will be shown as is, or not at all if pre-existing conditions are waived
3rd paragraph that begins "[We will not pay the Non-Invasive Cancer Benefit…."	Will be shown as is, or not at all if pre-existing conditions are waived
Benefit Payable Upon Reoccurrence of Invasive Cancer	
1st bullet that begins "[the invasive cancer is not caused or contributed…."	Will appear if plan includes Critical Illness.
Skin Cancer Benefit	
2nd bullet that begins [the skin cancer is diagnosed during the 12 months…."	Will be shown as is, or not at all if pre-existing conditions are waived
SECTION 12 – WELLBEING ASSISTANCE BENEFIT	Optional benefit and will appear as shown or not if benefit is selected
SECTION 13 – EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS	Exclusions and Limitations will be included or not based on the policyholder's plan
Pre-Existing Condition Limitation	Will be shown as is, or not at all if pre-existing conditions are waived
Continuity of Coverage	May be included in takeover situations
SECTION 14 – EXCLUSIONS AND LIMITATIONS FOR CANCER	Exclusions and Limitations will be included or not based on the policyholder's plan
Pre-Existing Condition Limitation	Will be shown as is, or not at all if pre-existing conditions are waived
Continuity of Coverage	May be included in takeover situations
SECTION 15 – TERMINATION OF INSURANCE	Leave of Absence Under the Family and Medical Leave Act pre-existing wording will appear or not, if pre-existing conditions are waived
SECTION 16 – GENERAL PROVISIONS	Section number will vary based on the policyholder's plan
SECTION 17 – CLAIMS PROVISIONS	Section number will vary based on the policyholder's plan

SECTION 18 – PORTABILITY	Entire section, as well as all provisions listed, will be included or not based on policyholder's choice In the Premiums provision, the options for prior notification dates are [45, 60, 90 and 120] days. Section number will vary based on the policyholder's plan

CANCER BENEFITS RIDER, R-GCI6000-CB

RIDER SCHEDULE	
Policyholder, Group Policy Number, Named Insured, Certificate Number, Coverage Type and Rider Coverage Effective Date	Will vary by policyholder and named insured
RIDER	
Company, address, phone number and website address	Company address, phone number and website address may be modified on any forms included in this filing, if changes occur in the future
Benefit Amounts	All benefit amounts are included on the Rider Schedule. One amount will be chosen
EXCLUSIONS AND LIMITATIONS FOR CANCER	Exclusions and Limitations will be included or not based on the policyholder's plan
Pre-Existing Condition Limitation	Will be shown as is, or not at all if pre-existing conditions are waived
Secretary Signature	Secretary Signature and title is subject to updates as names and/or titles change

FIRST DIAGNOSIS BUILDING BENEFIT RIDER, R-GCI6000-BB

RIDER SCHEDULE	
Policyholder, Group Policy Number, Named Insured, Certificate Number, Coverage Type, and Rider Coverage Effective Date	Will vary by policyholder and named insured
RIDER	
Company, address, phone number and website address	Company address, phone number and website address may be modified on any forms included in this filing, if changes occur in the future
Spouse Coverage	Will be available based on the policyholder's plan and can be 25%, 50**%,** 75%, or 100% of the First Diagnosis Building Benefit amount of the named insured If spouse coverage is not selected, the entire line will not appear
Dependent Children Coverage	Will be available based on the policyholder's plan and can be 25%, 50**%,** 75%, or 100% of the First Diagnosis Building Benefit amount of the named insured If child coverage is not selected, the entire line will not appear
First Diagnosis Building Benefit	
4th paragraph that begins ["We will pay the First Diagnosis Building Benefit if a covered person is diagnosed with a [critical illness (other than Coronary Artery Disease)] [or] …."	Will appear as shown or may be modified based on the policyholder's plan

4th paragraph, the 2nd bullet that begins["for a date of diagnosis during the 12 months following the rider effective date, the [critical illness…."	Will be shown as is, or not at all if pre-existing conditions are waived Will be modified based on the policyholder's plan
4th paragraph, the 3rd bullet that the [critical illness] [or]…."	Will be modified based on the policyholder's plan
5th paragraph that begins, "[or, in case of spouse or dependent children"….]	Will appear when there is spouse and/or dependent coverage
7th paragraph that begins, "[skin cancer or non-invasive cancer, as defined in the certificate to which the rider is attached, or] any [critical illness] [or]…."	Will appear if cancer is included in the policyholder's plan Will appear if cancer, critical illness or both are included in the policyholder's plan Pre-ex language will appear as shown, or not at all if pre-existing conditions are waived
8th paragraph that begins "[Invasive Cancer (Including all Breast Cancer must be diagnosed"….]	Will appear if cancer is included in the policyholder's plan
Secretary Signature	Secretary Signature and title is subject to updates as names and/or titles change

HEART BENEFITS RIDER, R-GCI6000-HB-DC

RIDER SCHEDULE	
Policyholder, Group Policy Number, Named Insured, Certificate Number, Coverage Type and Rider Coverage Effective Date	Will vary by policyholder and named insured
RIDER	
Company, address, phone number and website address	Company address, phone number and website address may be modified on any forms included in this filing, if changes occur in the future
EXCLUSIONS AND LIMITATIONS FOR COVERED HEART PROCEDURES	Exclusions and Limitations will be included or not based on the policyholder's plan
Pre-Existing Condition Limitation	Will be shown as is, or not at all if pre-existing conditions are waived
Secretary Signature	Secretary Signature and title is subject to updates as names and/or titles change

INFECTIOUS DISEASES RIDER, R-GCI6000-INF-DC

RIDER SCHEDULE	
Policyholder, Group Policy Number, Named Insured, Certificate Number, Coverage Type and Rider Coverage Effective Date	Will vary by policyholder and named insured
RIDER	
Company, address, phone number and website address	Company address, phone number and website address may be modified on any forms included in this filing, if changes occur in the future
EXCLUSIONS AND LIMITATIONS FOR INFECTIOUS DISEASES	Exclusions and Limitations will be included or not based on the policyholder's plan
Pre-Existing Condition Limitation	Will be shown as is, or not at all if pre-existing conditions are waived
Secretary Signature	Secretary Signature and title is subject to updates as names and/or titles change

PROGRESSIVE DISEASES RIDER, R-GCI6000-PD-DC

RIDER SCHEDULE	
Policyholder, Group Policy Number, Named Insured, Certificate Number, Coverage Type and Rider Coverage Effective Date	Will vary by policyholder and named insured
RIDER	
Company, address, phone number and website address	Company address, phone number and website address may be modified on any forms included in this filing, if changes occur in the future
Percentage of Applicable Face Amount	Will be available based on the policyholder's plan and can be 25%-100% in increments of 25%
EXCLUSIONS AND LIMITATIONS FOR PROGRESSIVE DISEASES	Exclusions and Limitations will be included or not based on the policyholder's plan
Pre-Existing Condition Limitation	Will be shown as is, or not at all if pre-existing conditions are waived
Secretary Signature	Secretary Signature and title is subject to updates as names and/or titles change

Colonial Life & Accident Insurance Company
Statement of Variability
Group Specified Disease Insurance Evidence of Insurability Form (GCI6000 E of I-DC)

1. **Simplified Issue Level 2 Section** - This section is bracketed to allow for future enhancements to underwriting, based on face amount and age of proposed insured.
2. **Simplified Issue Level 2** – **Question 18** – The "ever" is bracketed. The options are ever, within the past 10 years, within the past 15 years or within the past 20 years.
3. **Simplified Issue Level 2** – **Question 19** – The "ever" is bracketed. The options are ever, within the past 2 years or within the past 5 years.
4. **Simplified Issue Level 2** – **Question 20** – The "ever" is bracketed. The options are ever, within the past 15 years or within the past 20 years.

READABILITY COMPLIANCE CERTIFICATION

Name of Company: Colonial Life & Accident Insurance Company

This is to certify that the forms listed below meet the minimum score required by the Flesch Reading Ease Test.

Form and Form Number to which the Certification is Applicable:

Form No.	Flesch Score
GCI6000-P	52.1
GCI6000-C-DC	51.8
R-GCI6000-CB	50.6
R-GCI6000-BB	50.3
R-GCI6000-HB-DC	50.6
R-GCI6000-INF-DC	50.4
R-GCI6000-PD-DC	50.7
GCI6000 Port-DC (when scored with the policy forms)	50.9
GCI6000 Enroll-DC (when scored with the policy forms)	47.8
GCI6000 E of I-DC (when scored with the policy forms)	48
GCI6000SD19 (when scored with the policy forms)	49

Karen Sabasteanski

DATE: February 6, 2020

Karen Sabasteanski
AVP, Product Compliance
Colonial Life & Accident Insurance Co.
Post Office Box 1365
Columbia, South Carolina 29202

LN24044808990000001

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers who sell health insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association").

The purpose of the Guaranty Association is to provide statutorily-determined benefits associated with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons residing in the District of Columbia. However, the protection provided through the Guaranty Association is subjected to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in-force, with no change in contractual rights or benefits.

Coverage

The Guaranty Association, established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code § 31-5401 et seq.), provides insolvency protection for certain types of insurance policies and contracts.

The insolvency protections provided by the Guaranty Association is generally conditioned on a person being 1) a resident of the District of Columbia and 2) the individual insured or owner under a health insurance, life insurance, or annuity contract issued by a member insurer, or insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also covered under the Act, even if they reside in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- With respect to any one life, regardless of the number of policies, contracts, or certificates:
  - $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 for long-term care insurance benefits;
  - $300,000 for disability insurance benefits;
  - $500,000 for basic hospital, medical, and surgical insurance, or major medical insurance benefits;
  - $100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 in benefits with respect to any one life ($500,000 in the event of basic hospital, medical and surgical insurance or major medical insurance).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner of regardless of the number of policies owned.

Exclusions Examples

Policy or contract holders are not protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contacts.

Consumer Protection

To learn more about the above referenced protections, please visit the Guaranty Association's website at www.dclifega.org. Additional questions may be directed to the District of Columbia Department of Insurance, Securities and Banking (DISB) and they will respond to questions not specifically addressed in this disclosure document.

Policy or contract holders with additional questions may contact either:

District of Columbia
Department of Insurance, Securities and Banking
1050 First Street, Suite 801
Washington, DC 20002
(202) 727-8000

District of Columbia
Life and Health Guaranty Association
1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on the insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any rights established in any policy or contract or under the Act.

January 13, 2020

Commissioner of Insurance

RE: NAIC#: 0565 / 62049
Insurer: Colonial Life & Accident Insurance Company
Forms: GCI6000-P, et al
Type of Filing: Group Specified Disease

Dear Commissioner:

Attached for your review and approval are our new group specified disease policy, certificate, riders, and associated forms.

Form	Description	Flesch Score
GCI6000-P	Group Specified Disease Master Policy	52.1
GCI6000-C-DC	Group Specified Disease Certificate	51.8
R-GCI6000-CB	Group Cancer Benefits Rider	50.6
R-GCI6000-BB	Group First Diagnosis Building Benefit Rider	50.3
R-GCI6000-HB-DC	Group Heart Benefits Rider	50.6
R-GCI6000-INF-DC	Group Infectious Diseases Rider	50.4
R-GCI6000-PD-DC	Group Progressive Diseases Rider	50.7
GCI6000 Port-DC	Election of Group Specified Disease Insurance Portability Coverage	
GCI6000 Enroll-DC	Group Specified Disease Insurance Enrollment Form	
GCI6000 E of I-DC	Group Specified Disease Insurance Evidence of Insurability Form	
GCI6000SD19	Group Specified Disease Supplemental Data Form	

The forms do not replace any forms currently on file with your department. The readability scores for these forms are listed above. The text of the forms is uniform and no less than ten (10) point font size. These forms will be offered and marketed primarily at the worksite as supplemental insurance and not as a substitute for hospital or medical expense insurance or major medical insurance. Benefits provided are not intended to cover all medical expenses. There is no coordination of benefits. Please note all benefits are indemnity based.

These forms do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Coverage will be marketed to employer/employee groups by licensed Colonial Life & Accident Insurance Company agents and through relationships with insurance brokers. Premiums may be paid 100% by the employees or by full or partial contributions from the policyholder. This coverage may be marketed to associations and unions.

The group specified disease policy and certificate provides benefits for several critical illness conditions, additional critical illnesses for dependent children and cancer. The group policy also provides an optional Wellbeing Assistance Benefit.

We are also submitting several optional riders that provide coverage for supplemental critical illnesses, cancer, heart procedures, infectious diseases and progressive diseases.

Coverage amounts and which optional riders to offer will be chosen by the policyholder. The named insured will be able to select coverage options to meet their needs. The issue ages for this product will range from 16-74. Benefits are also available for spouse and dependent children.

Bracketed information is variable and may be removed or altered. A Statement of Variability is included with this filing and provides more detailed information regarding the requested variability.

The enrollment form, election of portability coverage form, evidence of insurability form and supplemental data form will be used with this product. The evidence of insurability form is bracketed for flexibility to support future enhancements to underwriting, based on face amount and age of the proposed insured. The supplemental data form will be used for overflow data from the additional data section on the enrollment and evidence of insurability forms. Form MAPP-DC, Application for Group Insurance, previously approved by your Department is the master application that is used with our group products. It was approved by your Department on 3/13/2013 under SERFF # UNUM-128907549.

An Underwriting Statement of Variability is also included with this filing and provides a more detailed explanation about the brackets within the evidence of insurability form.

Enrollment methods include agent-assisted situations, in person or via call centers and self-enrolled situations, using paper or electronic application processes, such as web-based. Electronic application processes may also be used in agent-assisted situations.

A separate rate filing has been submitted under SERFF# UNUM-132106301.

These forms have been submitted to our domicile state, South Carolina.

We reserve the right to alter the layout of these forms including ordering of the provision, color, typeface and font and to change variables as requested by a specific employer to accommodate future product design needs as long as such changes are in compliance with your state law without re-filing due to future technology changes (i.e. paper size, font, page numbers, ordering of the provisions, line ending or page ending changes). Any minimum font-size requirements will be in compliance with your state law. We also reserve the right to use these forms in an electronic format and certify that we will retain the approved final print format.

Thank you for your consideration. If acceptable, we shall appreciate your notifying us via SERFF. If you have any questions, please contact me at (800) 845-7330, extension 82962. My email address is blwessinger@coloniallife.com. The fax number is (803) 750-7341.

Sincerely,

Brandi Wessinger
Product Compliance Consultant

February 6, 2020

Re: Insurer: Colonial Life & Accident Insurance Company
NAIC #: 0565-62049
Forms: GCI6000-P-DC, et al
Type of Filing: Group Specified Disease

Dear Mr. Johnson:

This is a combined response to your objection letters for filing # UNUM-132106302. I will address your objections in order.

Objection #1
Please update your records and include the contact name below for your external appeal process language by deleting "Stephen C. Taylor."

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non -Medical Necessity cases,
Commissioner ,Department of Insurance, Securities and Banking
1050 First St. N.E., Suite 801
Washington, D.C. 20002
202-727-8000
Fax: (202) 354-1085

Response: *We have revised as requested.*

Objection #2
Amend the District of Columbia Department of Health Care Finance , Office of the Health Care Ombudsman and Bill of Rights ' address by inserting " Suite" in its address. As a result, the company's address in question should read
441 4th St. N.W., Suite 900 South , Washington, D.C. 20001
1 (877) 685-6391, (202) 724-7491, Fax: (202) 442- 6724

Response: *We have revised as requested.*

Objection #3
Review our bulletin number 01-IB-007-02/08 dated February 8, 2002, "Limited Benefit Alert" and insert, "Limited Benefit, Please Read Carefully" on the face page on these type of policies, certificates, riders, amendments, and endorsements.

Response: *We have revised form GCI6000-C-DC. This notice is already included in the remaining.*

Objection #4
Please review D.C. Statute 31-4712 c(1)(H) and include your "Time of Payment of Claims" language provision by stating " will be paid immediately upon receipt of due written proof of such law."

Response: *We have revised as requested.*

Objection #5
Our Departmental policy does not allow mandates or definitions to be bracketed. Only percentages, dates, number of days, and dollar amounts within the mandate provisions and definitions.

Instead, substitute the bracket with a text box (border) around your definitions ad mandates. You have the option of displaying a copy of the text boxes within the supporting documentation tab.

Response: *We have revised as requested.*

Objection #6
In our jurisdiction, spouse is not equated to a registered domestic partner or civil union partner. Therefore, please amend the spouse definition to " whenever the term Spouse appears in the Policy, this provision includes the Definition of registered domestic partner and civil union partner into the Policy."

Response: *We have revised as requested.*

Objection #7
Please confirm if your corresponding rate filing has been submitted to our Department.

Response: *Rates for this filing have been filed under SERFF # UNUM-132106302.*

Objection #8
Please review Jury and Marriage Amendment Act of 2009 and amend your " Family Member" definition to include the following: “civil union partner."

Response: *We have revised as requested.*

Objection #9
Review the D.C. § 31-4712 2(I) and include the Conformity with State Statutes provision Specifically, insert the following provision:

“Any provision in this Policy that is in conflict with the requirements of any state and/or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.”

Response: *We have revised as requested.*

Objection #10
Please review our D.C. 31-4725 & 31-4726 (flesch reading score) and include your certificate readability score on your forms not withstanding, applications, policies, certificates, amendments, riders, enrollments, evidence of insurability form, and endorsements. This includes items # 8 - # 11.

Response: *We have updated the readability certification as requested.*

Thank you for your assistance and your continued review of our filing. If acceptable, we shall appreciate your notifying us via SERFF. If you have any questions, please contact me at (800) 845-7330, extension 82962. My email address is blwessinger@coloniallife.com. The fax number is (803) 750-7341.

Sincerely,

Brandi Wessinger

Brandi Wessinger
Product Compliance Consultant

SERFF Tracking #:	*UNUM-132106302*	***State Tracking #:***		***Company Tracking #:***	*GCI6000 - FORMS*

State:	*District of Columbia*	***Filing Company:***	*Colonial Life & Accident Insurance Company*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*Group Critical Illness/Cancer*		
Project Name/Number:	*Group Critical Illness/Cancer /GCI6000*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/13/2020	Withdrawn 02/06/2020	Supporting Document	Readability Certification	02/06/2020	Readability Compliance Certification - DC.pdf (Superceded)

READABILITY COMPLIANCE CERTIFICATION

Name of Company: Colonial Life & Accident Insurance Company

This is to certify that the forms listed below meet the minimum score required by the Flesch Reading Ease Test.

Form and Form Number to which the Certification is Applicable:

Form No.	Flesch Score
GCI6000-P	52.1
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R-GCI6000-BB	50.3
R-GCI6000-HB-DC	50.6
R-GCI6000-INF-DC	50.4
R-GCI6000-PD-DC	50.7

DATE: January 13, 2020

Karen Sabasteanski

Karen Sabasteanski
AVP, Product Compliance
Colonial Life & Accident Insurance Co.
Post Office Box 1365
Columbia, South Carolina 29202